DOCUMENT RESUME

ED 380 246 RC 019 977

AUTHOR	Morse, Ann, Ed.
TITLE	America's Newcomers: An Immigrant Policy Handbook.
INSTITUTION	National Conference of State Legislatures, Denver, CO.; State and Local Coalition on Immigration.
SPONS AGENCY	Andrew W. Mellon Foundation, New York, N.Y.
REPORT NO	ISBN-1-55516-996-1
PUB DATE	Sep 94
NOTE	120p.; Chapter 3, Employment and Training Programs for Immigrants and Refugees, was published separately; see ED 371 081.
PUB TYPE	Information Analyses (070) -- Collected Works - General (020)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Access to Education; Adult Education; Cultural Pluralism; Educational Needs; Elementary Secondary Education; Eligibility; *Federal Legislation; Federal Programs; Health Services; *Immigrants; *Immigration; *Job Training; *Public Policy; Refugees; Social Services; State Programs
IDENTIFIERS	*Access to Health Care

ABSTRACT

This handbook contains five research papers and extensive reference materials on general immigration, immigrant policy, and related federal and state programs. "Immigration and Immigrant Policy" (Jonathan C. Dunlap) presents an historical overview of U.S. immigration, 1820s-1980s; defines various immigrant statuses and eligibility of each for federal programs; and describes the roles and responsibilities of federal, state and local governments, and the courts. "Health Care Issues for New Americans (Jonathan C. Dunlap, Fay Hutchinson) discusses immigrants' access to health care, public health issues related to immigration, mental health of refugees, and language and culture issues in service delivery. "Employment and Training Programs for Immigrants and Refugees" (Ann Morse) describes the Job Training Partnership Act and other federally funded training programs for disadvantaged adults and youth, training programs targeted at specific immigrant populations, licensing of foreign-born professionals, and unmet needs for English classes and other educational services. "Community Relations and Ethnic Diversity" (Ann Morse, Jonathan Dunlap) discusses public opinion about immigration, cultural diversity, and assimilation; language issues; community coalitions; incentives for citizenship; multilingual outreach programs; and mass media effects. "Federal Retrenchment, State Burden: Delivering Targeted Assistance to Immigrants" (Wendy Zimmerman) examines concentrations of immigrants and refugees in certain states; state costs; reductions in public assistance, language and job training, and health and social services; and implications for policy reform. Appendices contain a chronology of federal immigration legislation and a directory of immigrant policy contacts by state. This handbook contains 70 selected references, additional references in each chapter, and an index. (SV)

ED 380 246

AMERICA'S NEWCOMERS

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Ann Morse

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

BEST COPY AVAILABLE

An Immigrant Policy Handbook

RC 019 977

AMERICA'S NEWCOMERS

An Immigrant Policy Handbook

IMMIGRANT POLICY PROJECT
STATE AND LOCAL COALITION ON IMMIGRATION

Edited by
Ann Morse
Program Manager

National Conference of State Legislatures
William T. Pound, Executive Director

1560 Broadway, Suite 700
Denver, Colorado 80202

444 N. Capitol Street, NW, Suite 515
Washington, D.C. 20001

September 1994

©1994 by the National Conference of State Legislatures. All rights reserved.
ISBN 1-55516-996-1

CONTENTS

LIST OF TABLES AND FIGURES iv

STATE & LOCAL COALITION ON IMMIGRATION, IMMIGRANT POLICY PROJECT v

National Advisory Board Members v
Governing Board v
Members of the Panel of Experts vi

PREFACE AND ACKNOWLEDGMENTS vii

EXECUTIVE SUMMARY ix

1. IMMIGRATION AND IMMIGRANT POLICY 1

Introduction 1
A Nation of Immigrants 1
Two Waves of Immigration 3
Immigration Status 6
The Newcomer in the 1990s 8
How the System Works 10
Federal Immigration Law 12
Conclusion 18
Glossary 19
References 20

2. HEALTH CARE ISSUES FOR NEW AMERICANS 21

Introduction 21
Access to Health Care 22
Public Health 24
Refugee Mental Health 26
Language and Culture 28
Conclusion 31
References 33

3. EMPLOYMENT AND TRAINING PROGRAMS FOR IMMIGRANTS AND REFUGEES 34

Introduction 34
Federal Programs for Employment and Job Training 35
Immigrant and Refugee Programs 39
Discussion 42
Conclusion 45
Notes 47
References 47

4. COMMUNITY RELATIONS AND ETHNIC DIVERSITY 49

Introduction 49
The Ambivalent Welcome 50
Melting Pot or Salad Bowl? 51
Coping with Diversity 54
Conclusion 63
Notes 64
References 65

5. FEDERAL RETRENCHMENT, STATE BURDEN: DELIVERING TARGETED ASSISTANCE TO IMMIGRANTS 66

Introduction 66
A Brief History of the Refugee Program 67
A Brief History of SLIAG 69
Concentration of Immigrants and Refugees 70
Study Approach 70
Limitations of Data 71
State Costs 73
Growing Needs and Reduced Services 76
Reductions in Public Assistance 76
Reductions in Language and Job Training 76
Reductions in Health Services 79
Maintaining and Expanding Social Services 80
The Legacy of the Refugee Program and SLIAG 81
Implications for Policy Reform 82
Conclusion 83
Notes 85
References 87

APPENDIXES

A. Chronology of Immigration Legislation 89
B. Contacts on Immigration and Immigrant Policy 91
State and Local Government 91
Federal Government 97
Non-Governmental Organizations 97

SELECTED REFERENCES ON IMMIGRATION AND IMMIGRANT POLICY 99

INDEX 103

LIST OF TABLES AND FIGURES

TABLES

1. Overview of Alien Eligibility for Federal Programs 7
2. Refugee Admissions and Refugee Resettlement Funding: 1980-1994 68
3. Reductions in Refugee Cash and Medical Assistance 68
4. Refugee Arrivals by State: FY 1992 71
5. Legalization Applicants by State: FY 1992 72
6. Benefit Structures and Payment Levels of Selected States: FY 1992 74
7. State Reported Uncompensated Refugee Costs by Program: FY 1991 75
8. Refugee Program Funding by Type of Service: FY 1984 and FY 1992 77
9. Limited English Proficiency (LEP) and Foreign-born Populations by State: 1990 78
10. SLIAG Costs by Program: FY 1987-1993 81

FIGURES

1. Refugee Resettlement Funds vs. Refugee Arrivals 4
2. Federal Refugee Assistance: Reimbursement to the States: 1981 to 1991 4
3. Immigration to the United States by Decade: 1821-1830 Through 1981-1990 5
4. Legal Immigration to the United States in FY 1991 9
5. Cumulative Refugee Arrivals, FY 1975 through FY 1991 10

STATE & LOCAL COALITION ON IMMIGRATION
IMMIGRANT POLICY PROJECT

National Advisory Board Members

Kevin W. Concannon, Director, Oregon Department of Human Resources

David P. Forsberg, Secretary, Massachusetts Executive Office of Human Services (1992-1993)

Ann Klinger, Supervisor, Merced County, California

Alexander Penelas, Commissioner, Dade County, Florida (1993-)

Ann W. Richards, Governor, Texas

Harvey Ruvin, Commissioner, Dade County, Florida (1992-1993)

James Scheibel, Mayor, Saint Paul, Minnesota (1992-1993)

Art Torres, State Senator, California State Senate

Albert Vann, State Assemblyman, New York State Assembly

Karen Vialle, Mayor, Tacoma, Washington (1992-1993)

William Waldman, Commissioner, New Jersey Department of Human Services (1993-)

Pete Wilson, Governor, California

Governing Board

National Conference of State Legislatures
William T. Pound, Executive Director
Sheri Steisel, Director, Human Services Committee

National Governors' Association
Raymond Scheppach, Executive Director
Nolan Jones, Director for Justice and Public Safety

National Association of Counties
Larry Naake, Executive Director;
Marilina Sanz, Associate Legislative Director for Human Services

United States Conference of Mayors
Thomas Cochran, Executive Director;
Laura DeKoven Waxman, Assistant Executive Director

American Public Welfare Association
A. Sidney Johnson, Executive Director
Elaine Ryan, Director of Government Affairs

MEMBERS OF THE PANEL OF EXPERTS

Robert Bach, Senior Policy Adviser, U.S. Immigration and Naturalization Service, Washington, D.C.

Michael Fix, Director, Immigrant Policy Program, The Urban Institute, Washington, D.C.

Charles Keely, Director, Center for Immigration Policy and Refugee Assistance, Washington, D.C.

Lavinia Limón, Director, U.S. Office of Refugee Resettlement, Washington, D.C.

Susan Martin, Executive Director, U.S. Commission on Immigration Reform, Washington, D.C.

Doris Meissner, Commissioner, U.S. Immigration and Naturalization Service, Washington, D.C.

Cecilia Muñoz, Senior Policy Associate, National Council of La Raza, Washington, D.C.

David North, New TransCentury Foundation, Virginia

Demetrios Papademetriou, Senior Associate, Carnegie Endowment for International Peace, Washington, D.C.

Theresa Rusch, Acting Deputy Assistant Secretary, U.S. Department of State, Washington, D.C.

Frank Sharry, Executive Director, National Immigration Forum, Washington, D.C.

Rick Swartz, President, Swartz and Associates, Washington, D.C.

Tsehaye Teferra, Executive Director, Ethiopian Community Development Council, Virginia

Luis Torres, Director, InterAmerican Institute on Migration and Labor, Washington, D.C.

PREFACE AND ACKNOWLEDGMENTS

These issue papers were produced by the Immigrant Policy Project of the State and Local Coalition on Immigration, a collaboration of five national organizations representing state and local government:

American Public Welfare Association
National Association of Counties
National Conference of State Legislatures
National Governors' Association
United States Conference of Mayors

The goals of the coalition are to improve intergovernmental coordination and communication among the key state and local officials and other relevant actors in the immigration community, and to enhance the capacity of state and local officials to manage immigrant policy.

The Immigrant Policy Project was begun in 1992 with the support of The Andrew W. Mellon Foundation. The project's goal is to address the role of state and local governments in the resettlement of refugees and immigrants. The project performs research and education, acts as a central source of information for the coalition, and channels information to the coalition's constituencies. The project seeks to document immigration trends, innovative policies and programs, and priorities for state and local government.

The issue papers in this handbook benefited from the insight, advice, and technical expertise of many state and local officials and immigration specialists. The project is particularly grateful to our expert panel for their comments. Thanks are also due to the members and staff of the project's National Advisory Board for providing focus, to Stephanie Bell-Rose for providing guidance, and to a number of federal, state and local immigration experts and researchers (especially SCORR), who provided support and information. Special appreciation is due to the following experts for assistance with specific issue papers.

For *A State and Local Policymaker's Guide to Immigration and Immigrant Policy*, authored by Jonathon C. Dunlap of the Immigrant Policy Project, thanks are owed to David Rosenberg, Ann Dee Tucker, Charles Wheeler, Carol Wolchok, and Wendy Zimmermann. Edits and comments were provided by Ann Morse, Sheri Steisel, Michael Bird, and Karen Fisher.

For *Health Care Issues for New Americans*, authored by Jon Dunlap and Fay Hutchinson of the Immigrant Policy Project, we thank Barbara Brown, Luis Caraballo, Jennifer Cochran, Monica Perz, Ed Silverman, Joy Johnson Wilson, and Wendy Zimmermann.

For *Employment and Training Programs for Immigrants and Refugees*, authored by Ann Morse, program manager of the Immigrant Policy Project, many thanks go to the researchers and labor specialists who assisted in providing background research and specific examples and recommendations. Edits and comments were provided by Michael Bird, Scott Liddell, David Shreve, and Sheri Steisel.

For *Community Relations and Ethnic Diversity*, co-authored by Ann Morse and Jon Dunlap, we thank Elizabeth Aivars, Julie Quiroz, Trudy Sopp, Ron Wakabayashi, and Wendy Zimmermann. Comments were provided by Sheri Steisel, Joy Johnson Wilson, and Chris Zimmerman.

Federal Retrenchment, State Burden: Delivering Targeted Assistance to Immigrants was written by Wendy Zimmermann, research associate at the Urban Institute. The survey was conducted jointly by the Urban Institute's Immigrant Policy Program and the American Public Welfare Association, as a member of the State and Local Coalition on Immigration. The author thanks Gabe Negatu for his help in implementing the survey on which the report is based, Nolan Malone for research assistance, and Michael Fix, Ann Morse, David Rosenberg, and Elaine Ryan for their helpful comments and suggestions.

Finally, the Immigrant Policy Project owes its genesis and its continued success to an extended family of coalition staff for their thoughtful advice, assistance, and creativity, particularly co-creators Michael Benjamin, Susan Greene, Jana Mason, Lilia Reyes, and Sheri Steisel as well as Rick Ferreira, Tom Joseph, Nolan Jones, Brian Lagana, Alicia Pelrine, Elaine Ryan, Marilina Sanz, Margie Siegel, Laura Waxman, and Amy Wilkins.

This handbook is a compilation of work produced by the State and Local Coalition on Immigration through its Immigrant Policy Project. Five research papers examine general immigration and immigrant policy in the United States; health care issues; employment and training programs; community relations and ethnic diversity; and the effects of declining targeted assistance for refugees and immigrants. The first paper, a guide to immigration and immigrant policy, has been revised and updated since its initial publication in February 1993. The handbook includes extensive reference materials, compiled by the project over three years: a brief chronology of U.S. immigration legislation; a contact list of federal, state, local, and nongovernmental representatives experienced in immigration issues and a bibliography of recent articles, studies, and reports related to immigration and immigrant policy.

Immigration and Immigrant Policy

The United States is in the largest wave of immigration since the turn of the century: one-third of the nation's net population growth in the 1980s came from immigration. As more immigrants and refugees arrive in the United States, state and local governments are attempting to meet their needs for education, job placement, and health and human services. The sheer numbers of immigrants from many countries and with varying job skills and language ability are having a dramatic effect on states and localities.

Although the federal government has exclusive jurisdiction over immigration policy (the terms and conditions for entry into the United States), federal decisions have direct and indirect effects on state and local governments in the form of their budgets; the composition of their citizenry; the utilization and quality of their services; and the general social, political, and economic character of their communities. Though more immigrants are arriving, the federal government has reduced or constrained the few programs that assist new immigrants to integrate into the economic, social, and civic life of the United States. Finally, new legislative and judicial mandates are extending state and local responsibility for providing services to immigrants. For states and localities, federal immigration policy thus becomes state and local immigrant policy.

Since the end of World War II, the numbers of immigrants have increased steadily each decade, reaching 9.5 million between 1981 and 1990. Although the early groups were predominantly Europeans and Canadians, by the end of the 1980s more than 80 percent of all immigrants were non-European, mostly Asians and Latin Americans.

Immigrants are typically described as legal (entering to join families or to work), humanitarian (as refugees), or unauthorized (entering illegally or overstaying their visas). A growing number of federally funded categories has established varying rules of eligibility for work and for public benefits, complicating state and local delivery of services.

The federal government plays three roles in the immigration and immigrant policy dynamic that concern states and localities: (1) regulating admissions into the United States; (2) funding resettlement assistance for very limited and specific groups of newcomers; and (3) determining newcomer eligibility for federal programs. The courts, too, shape policy; several decisions have required states and localities to allow certain groups to receive benefits. Private agencies also help resettle newcomers. Finally, states and localities play a significant role in emergency and transitional assistance for newcomers through emergency health, education, social services, civics and language courses, and other programs that contribute to their successful resettlement.

Three major laws were passed in 10 years that reformed humanitarian, illegal, and legal immigration: the Refugee Act of 1980, the Immigration Reform and Control Act of 1986, and the Immigration Act of 1990. Each law affects immigrants' status and rights, and each has implications for state and local policy.

The number and diversity of the new immigrants are creating new fiscal and social challenges for state and local governments. The lack of a comprehensive federal policy to provide adequately for the resettlement of refugees and immigrants is compelling state and local government to create immigrant policy, but without adequate resources. Economists show that two-thirds of the income provided by immigrants flows to the federal level, while only one-third flows to states and localities. Yet the education and health care needs of new

arrivals cause states and localities to incur significant costs. The federal jurisdiction over immigration must be adjusted to equitably respond to the needs of both the new immigrants and of state and local governments, as partners in the intergovernmental system.

Health Care Issues for New Americans

Immigrants and refugees are among the millions of people who are currently without health insurance, are insured only part of the year, or whose insurance is inadequate in the event of a catastrophic illness. The demand for newcomer health care services continues to surpass the budgetary and program resources of state and local governments. As discussions continue on health care reform, the specialized needs of newcomers and their differing eligibility for federal services need to be considered.

Newcomers face several barriers to adequate, comprehensive health care. Institutional barriers, such as legal status and program eligibility requirements, prevent some categories of newcomers from participating in government-sponsored health care programs. Foreign languages and cultures contribute to miscommunication between service providers and newcomer patients. Economic obstacles prevent many newcomers from purchasing health care on their own.

Federal programs designed to meet newcomers' health care needs are inadequate and fragmented, and over the last decade, the federal government has been shifting newcomer health care responsibilities to state and local governments. In response, state and local governments are beginning to design policies and programs to meet the health care needs of this diverse population. However, because their resources are limited, these models are rare and difficult to replicate.

Four health care policy areas particularly affect newcomers: access to regular and comprehensive health care; public health; mental health; and the effect of linguistic and cultural barriers on newcomers' use of health care. Sections of this chapter discuss newcomers' needs and problems within each specific area, the current federal response, and some successful state and local programs.

If newcomers have access to regular and comprehensive health care, they can receive primary care in doctors' offices, obviating the use of hospital outpatient departments and emergency rooms, which increases costs to state and local governments. Public and preventive health issues raised by newcomers (particularly the high incidence of tuberculosis, hepatitis B, and parasites) have serious implications for both newcomers and natives. Immigrants, too, have mental health problems, particularly refugees who have suffered the horrors of persecution or torture. Finally, communication problems, either linguistic or cultural, between health care provider and patient may significantly compromise the quality of health care received and the efficacy of treatment.

Fragmentation of the U.S. health care system adversely affects newcomer access to adequate health care, and newcomers who can gain access are often poorly served because providers do not usually have multilingual and multicultural resources for appropriate and effective care. States, localities, and others are trying to compensate for deficiencies in the current system through supplemental programs or policies but do not have the resources to develop comprehensive approaches. Without improved health care access for newcomers, federal, state, and local governments will be unable to provide efficient, inexpensive, and appropriate care to these populations.

Newcomer health care needs affect not only the individuals themselves, but also the communities in which they live. When newcomers are healthy, they have better prospects for early employment, self-sufficiency, and successful integration into their new communities. Health care access for newcomers is a cornerstone of successful resettlement policy.

Employment and Training for Refugees and Immigrants

Immigrants are a growing proportion of the American workforce: the U.S. Department of Labor predicts that by the year 2000 nearly one-fourth of new workers will be immigrants. Many immigrants have limited skill in English and a low level of schooling, a fact that has serious implications for the nation's current employment and training system. Federal job training programs serve a small percentage of the eligible population, and the few targeted programs for refugees and immigrants have endured drastic funding reductions and delays. At the same time, language and literacy barriers reduce access to these programs for refugees and immigrants.

This report outlines the provisions of the Job Training Partnership Act, the Job Opportunities and Basic Skills program, and the two U.S. Health and Human Services programs for newly legalized immigrants and refugees. It includes recent evaluations of these programs and examples of successful programs that serve the foreign-born.

Increased numbers of immigrants in the nation's workforce will require rethinking of the delivery of education, employment, and training to traditional and nontraditional U.S. workers. The existing employment and training programs are fragmented, lack adequate resources, and discourage access by immigrants and refugees. No preparations have been made to meet the demand for services of the newly legalized formerly served by the State Legalization Impact Assistance Grant program. Finally, the refugee program has faced repeated funding cuts and is again up for reauthorization in 1994.

In a related arena, the federal government is proposing welfare reform and a new system of welfare to work. Addressing the needs of nonnative eligible public assistance recipients will be a challenge in federal, state, and local welfare reform efforts. As the "new social contract" is developed between public assistance recipients and the government, appropriate program support—such as classes in English as a second language, bilingual educators, and acculturation within government programs and the workplace—must be available to support the welfare-to-work transition for targeted as well as mainstream populations.

As policymakers craft reforms of their welfare, education, employment, and training programs for improved self-sufficiency and workforce skills, the requirements of a growing immigrant population must be examined and addressed. Successful programs discussed in this paper should not be overlooked, such as combined language and vocational training, comprehensive services such as Job Corps, and coordinated services that address family self-sufficiency.

Community Relations and Ethnic Diversity

Is the melting pot boiling over? Recent outbreaks of violence in U.S. cities have led some observers to question whether the nation can continue to absorb large numbers of newcomers without paying a high price in ethnic strife. However, federal jurisdiction over immigration policy limits the flexibility of states and localities to respond, and a steady decline in federal assistance for resettlement services is raising community tensions and issues of equity.

The challenge of state and local policymakers is to provide basic services with few resources in communities made up of diverse ethnic and social groups, most of whom are legally residing in the United States. What programs and policies can be created that are inclusive and responsive to the needs of both newcomers and established residents?

Researchers and policymakers alike point to the success of increased interaction and communication among community residents in easing tensions. For example, all residents have a stake in safe neighborhoods and quality schools. Policymakers can support good community relations in their roles as leaders in the community, as shapers of public opinion, and creators of policies and programs that equitably serve all community residents and that attempt to overcome the language and cultural barriers that often lead to tensions within the community.

This issue paper examines the nation's historical ambivalence toward the foreign-born as shown in legislation, policies, and opinion polls; makes recommendations for building community from diversity; and gives examples of successful programs. The recommendations are in six broad areas: leadership, participation and community coalitions, citizenship, inclusive policies and programs (in multicultural outreach, language, law enforcement, and economic development), special offices or committees for immigrant issues, and media relations.

Federal proposals raised by Congress in 1994 would curtail or bar access by certain classes of immigrants from federal assistance, mainly as a source of financing for welfare reform or for budget deficit reduction. However, an end to federal financial assistance for newcomer services does not mitigate the newcomers' needs for services or state and local responsibilities for public health and safety.

State and local policymakers hold key roles in developing and maintaining strong community relations among all residents, and they continue to discover new ways of building community from diversity.

Federal Retrenchment, State Burden: Delivering Targeted Assistance to Immigrants

This new study, conducted by the American Public Welfare Association and the Urban Institute, confirms that reduced targeted federal assistance for immigrants shifted costs to states and localities.

According to the 1990 census, 20 million foreign-born people are living in the United States. Approximately one million are refugees, and 2.6 million are immigrants who entered illegally but were granted amnesty under the Immigration Reform and Control Act of 1986. Although these two groups make up only a fraction of the total foreign-born population, almost all targeted federal money for newcomers has been allocated to states and localities through the domestic refugee resettlement program and the State Legalization Impact Assistance Grant (SLIAG).

To document the fiscal, programmatic, and institutional effects on states of policy shifts within the refugee program and SLIAG, the Urban Institute and APWA conducted a survey of the state administrators of the refugee program and SLIAG. The study suffers from a limitation common to many studies assessing fiscal impacts of immigrants —the limited availability of data on the costs of providing services to newcomers. Many states do not track specific immigrant populations participating in their public welfare programs. Among those that do, there is considerable variation in how they document the services used. Therefore, the survey does not attempt to estimate total immigrant and refugee costs for all state and local governments; rather, it provides data for selected states on the costs of providing certain services to refugees and amnesty immigrants.

Although the number of refugees admitted has more than doubled since the early 1980s (from 60,000 in 1983 to 122,000 in 1993), federal funding has been reduced dramatically, from $7,300 per refugee in 1982 to about $2,200 in 1992 (adjusted for inflation). Federal reimbursement for refugees dropped from the original 36 months of special cash and medical assistance to eight months. Reimbusement for the state share of AFDC, Medicaid, SSI and General Assistance ended completely. State costs resulting from these cuts vary significantly, because of differences in benefit program structures, payment levels, welfare usage, and capacity to track or estimate costs. For FY 1991, 19 states reported AFDC costs for refugees of $87.5 million (including California's estimated costs of $81 million for FY 1994). Fifteen states reported state and local Medicaid costs of $9.8 million, and six states reported $9.6 million in cost-shifts under General Assistance. SLIAG, unlike the refugee program, was fully funded. States reported, however, that costs that should have been reimbursed were not because of the way in which the program was defined and implemented. Six states reported costs of $24.45 million for providing services that were not reimbursable (day care, food, shelter, and child protective services).

Federal funds for refugee social services also declined dramatically, while the need for services increased. Many arriving in the late 1980s had less education and less proficiency in English than earlier arrivals, and the loss of cash and medical support heightened the need for refugees' early employment and self-sufficiency. Of all social services, the survey found that states most often reduced English language training, although some states, usually those with small numbers of refugees, expanded language training despite decreased funding. Health services were also reduced as funding decreased; states cut back on immunizations, health screenings and follow-up care, sometimes leading to increased use of emergency services.

A bright note is that the refugee program and SLIAG have improved states' institutional capacity to serve newcomers. Several states have created state-level offices for newcomers, supported networks of providers, determined newcomers' service needs, and, to an extent, helped make mainstream institutions more accessible to them.

In summary, decreased funding in the refugee program has shifted costs to states and localities. The survey results point to the need to better track the costs of providing services to refugees and immigrants to better assess the impacts of these populations on the public coffers. Declining refugee program funds have resulted in reduced public assistance, social services, and health services in many states. Although SLIAG program funds were fully appropriated, burdensome federal requirements for documentation has led some states to simply absorb costs. The two programs enhanced states' institutional capacity to serve newcomers. However, the states' ability to maintain this capacity is threatened by the combined effect of declining refugee program dollars and the termination of the SLIAG program.

1. Immigration and Immigrant Policy

Jonathan C. Dunlap
National Conference of State Legislatures

It's very, very important that we in government, the private sector, the volunteer sector, recognize that newcomers to this country are assets, that we have a cultural diversity that should be held up and celebrated, and that we have an obligation as a government to design policies that foster diversity.

Secretary Davis P. Forsberg
Massachusetts Executive Department of
Health and Human Services

Chapter 1 was originally published as America's Newcomers: A State and Local Policymakers' Guide to Immigration and Immigrant Policy *by the National Conference of State Legislatures, February 1993.*

Introduction

The United States is a nation of immigrants, from the first "boat people," the Pilgrims, to the latest migrants, who come here seeking political asylum, economic opportunity, and reunion with family members. The face of America is changing dramatically: one-third of the nation's population growth in the 1980s is attributable to immigration. This demographic change brings new challenges for state and local government in providing education, health care, and other services to a new and diverse community.

But even though more immigrants are arriving, the federal government has reduced or constrained the few programs that assist new immigrants to integrate into the economic, social, and civic life of the United States. Federal funding for refugees, legalized aliens, and for immigrant education programs has been cut substantially or delayed. For the most part, the responsibility for integrating immigrants into society has been left to state and local government, private organizations, and the immigrants themselves.

State and local responsibility for newcomers is also being increased by new legislative and judicial mandates for immigrant services. For example, the Refugee Act of 1980 requires states to provide cash and medical assistance to refugees; the Immigration Reform and Control Act of 1986 allows access to public assistance, health and educational services to newly legalized aliens; and the 1982 U.S. Supreme Court case *Plyler v. Doe* extends public education benefits to undocumented children.

As a result of these trends in federal immigration policy (increasing immigration, decreasing federal assistance, and additional mandates), state and local policymakers are encountering new fiscal and social challenges. In response, they are creating "immigrant policy," programs and services that meet the needs of a diverse, multiethnic citizenry.

These new arrivals affect a range of government services, from education to community relations to health and human services, which in turn raises issues of funding, inclusion, and equity. Some states and localities have created offices or legislative bodies to address the needs of the foreign-born. Others have created innovative programs or adapted mainstream programs to serve a variety of areas to assist immigrants make a successful transition to their new community. This guide has been developed to provide an overview of federal legislation and the immigration process and to illustrate the effects of federal immigration policy on states and localities.

A Nation of Immigrants

Americans are proud of their immigrant heritage and the principle of freedom and opportunity symbolized by the Statue of Liberty. Our nation stands as a beacon for the world's "huddled masses yearning to breathe free."

Immigrants in our communities are often met with a mixture of welcome and reservation. Some citizens are concerned that immigrants threaten the

BEST COPY AVAILABLE

nation's economic and social well-being. Immigrants are accused of abusing government assistance programs, contributing little or no tax revenue to the public coffers, taking jobs from U.S. citizens, and failing to adjust to new communities.

History shows that these reservations are not a unique response. During the mass immigration between 1880 and 1910, when almost 18 million immigrants entered the United States, high levels of immigration evoked similar concerns in the citizens of that day. Immigrants, it was feared, threatened the cultural and moral fiber of American society. Immigrating Italians, Poles, Germans, Slavs, and Jews were considered inferior and not likely to assimilate with their northern and western European predecessors.

But while the history books reveal a pattern of anxiety on the part of some citizens, they also indicate that these concerns are often misplaced and unfounded. For example, at the turn of the 20th century, newcomers served as a source of valuable labor, helping to build the country's

Immigration, The Labor Force, and The Economy

There are a number of schools of thought about the effect of immigrants on the U.S. labor force and economy. A primary reason for differing opinion is that immigrants are such a diverse population. Each legal status (legal immigrants, humanitarian immigrants, and illegal immigrants) affects the labor market and the economy in different ways.

One school of thought has found immigration to have a positive impact on the labor market and the economy. A 1988 national study of Hispanic immigration by economist Gregory Defreitas found that this immigration had "no significant negative effect on wage levels of low-skilled native men" and that "recent immigration has not had substantial adverse wage or employment effects." Similar studies by labor economist Julian Simon of the University of Maryland and Ben Wattenberg of the American Enterprise Institute, among others, have come to comparable conclusions.

Additionally, the Alexis de Tocqueville Institute recently found that "immigrants do not just fill jobs, they create jobs. They do this by creating new businesses; through their spending; through the investment capital they bring with them; by migrating to areas where jobs are most plentiful; and by raising the productivity of United States businesses."

Other data compiled by economist George Borjas of University of California—Santa Barbara, and reported in *Business Week* magazine (7/13/92) makes nationwide estimates concerning newcomer income, tax contributions, and welfare use. According to this estimate, at least 11 million immigrants are employed, earning $240 billion per year and paying $90 billion in taxes per year. The data further estimate that immigrants receive $5 billion in welfare annually.

However, other labor economists, such as Vernon Briggs of Cornell University, are somewhat less optimistic in their analysis of immigration (particularly unskilled, undocumented immigrants) and its impact on the labor market. Briggs' research has indicated that immigration of unskilled newcomers has a tendency to depress wages in low-skill job markets, thereby affecting other low-skill populations, both immigrants and citizens alike. A study by the Department of Labor found that heavy immigration in the Los Angeles area led to poorly enforced labor standards and increased inequity between the wealthy and the poor.

Perhaps a 1989 report by the United States Department of Labor best sums up the relationship between immigration and the economy: "There is no single bottom-line, 'labor market effect' of immigration. . . . The use of immigrant workers as low-cost labor may simultaneously constrain the wage rates and job opportunities of similarly qualified natives, improve the survival prospects of the employing firm and thereby secure the employment and earnings of better-trained co-workers, and lower costs to domestic consumers."

infrastructure and to fuel the engine of America's Industrial Revolution. These immigrants proved to be hard working, honest, and often entrepreneurial citizens.

Today's newcomers, now mostly from Asia, Latin America, and the Caribbean, are proving many of our current concerns to be similarly unfounded. During the 1980s, 1.5 million immigrants with college degrees arrived in the United States. These newcomers fill needs for engineers, health care professionals, scientists, computer programmers, and managers. Other, less-educated newcomers make contributions as entrepreneurs, day laborers, child care providers, and taxi drivers.

Although immigrants have proved to be economic and cultural assets, they make demands on state and local governments. In California, newcomers have put a strain on public resources and infrastructure. More than one-third of all newcomers settle in the Golden State. In New York City, it is not unheard of to have more than 100 languages spoken in one school district. In Minnesota's Twin Cities, a substantial Southeast Asian population is compelling state and local social service delivery systems to accommodate new cultural and religious traditions. In many other states and localities, newcomers put additional demands on scarce public resources as well. These newcomers require health care, education, job training, police, emergency services, social services, and housing.

Although the United States has promoted a generous immigration policy, allowing many people to enter the country, the federal government has never been forthcoming with substantial resources for "immigrant policy," that is, for immigrant resettlement. The aid the federal government does provide is targeted at narrowly defined groups (e.g., refugees, legalized aliens) that exclude many other immigrants. Those immigrants who fall outside the purview of federal resettlement programs are allowed to access federal and state-federal mainstream assistance programs after a three-year waiting period (see the "Three-year deeming" box on page 15). When these immigrants finally do get into these programs, the services they receive are not as specialized as immigrants need. For example, immigrants may need interpreters or instruction in English as a second language (ESL) in addition to basic services.

The lack of federal resettlement assistance is being exacerbated by a sluggish economy and decreasing tax revenues at the federal, state, and local levels. For example, the recession and the ensuing competition for limited government revenue have quickly reduced what little federal aid the government provides to needy refugees (see figures 1 and 2). Figure 1 demonstrates the decline in federal funding for refugee programs and the simultaneous increase in the number of refugees arriving in the United States. Figure 2 documents the reduction in federal reimbursement provided to states to subsidize the costs states incur by serving the refugee population.

On the state and local levels, spending for programs that normally assist immigrants, such as education, ESL, interpreter services, public assistance, indigent health care, and so on, is being reduced or eliminated. With fewer services, immigrants face significant barriers to becoming self-sufficient members of their new communities.

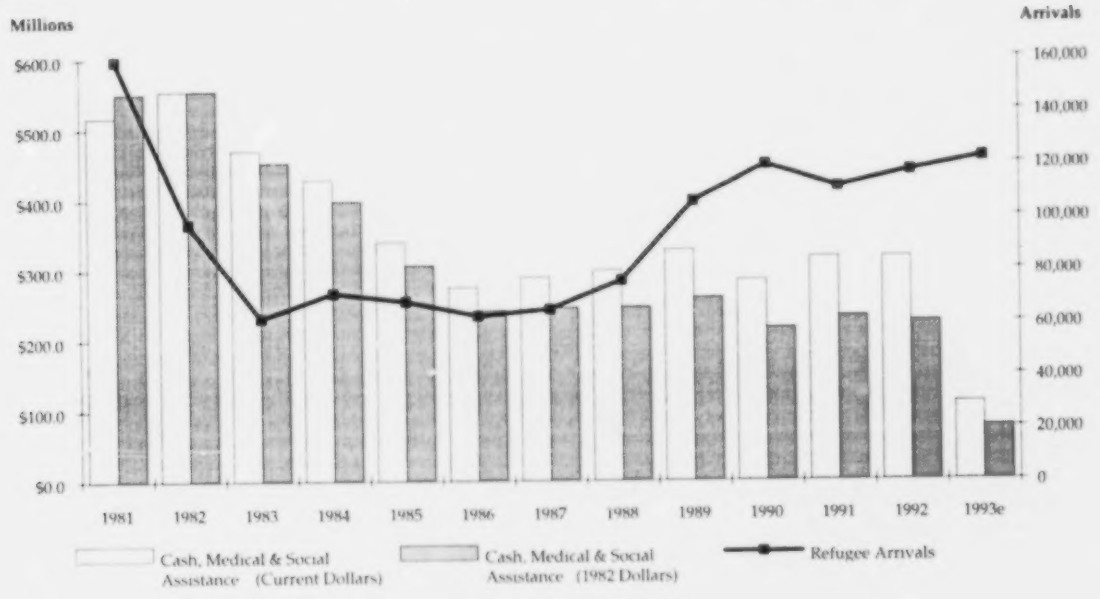
Nevertheless, a few states and localities are successfully assisting immigrants despite this budgetary pressure. By combining pots of money from various sources, states, cities and counties are providing immigrants with education and employment assistance and some limited support services, such as child care and translation services. These temporary services enable most immigrants to successfully make the transition to self-sufficiency.

Two Waves of Immigration

There have been two principal "waves" of immigration to the United States in its modern history (see figure 3). The first began in the 1840s, as revolutionary upheaval and agricultural famine in Europe caused hundreds of thousands of Northern and Western Europeans (e.g. Irish, Germans, English, and Scandinavians) to immigrate to this country. This wave of immigration swelled throughout the late 1800s and culminated in the mass immigration of the early 1900s, when 8.9 million immigrants entered the country between 1900 and 1910.

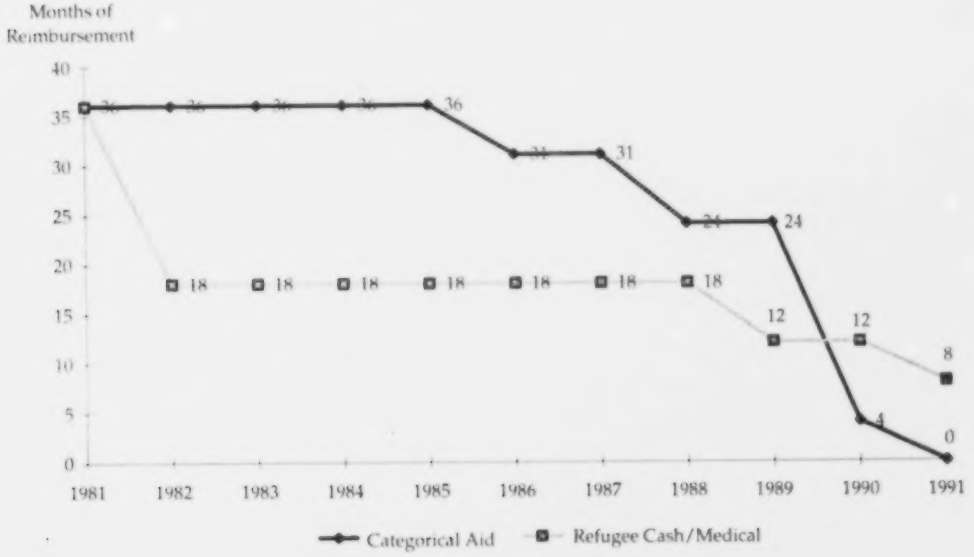
By the end of this wave, immigrants were primarily from Southern and Eastern Europe and Canada. At the height of this mass immigration, immigrants accounted for 9.6 percent of the total United States population.

Figure 1
Refugee Resettlement Funds vs. Refugee Arrivals



Prepared by the National Conference of State Legislatures, October 1993

Figure 2
Federal Refugee Assistance: Reimbursement to the States: 1981 to 1991

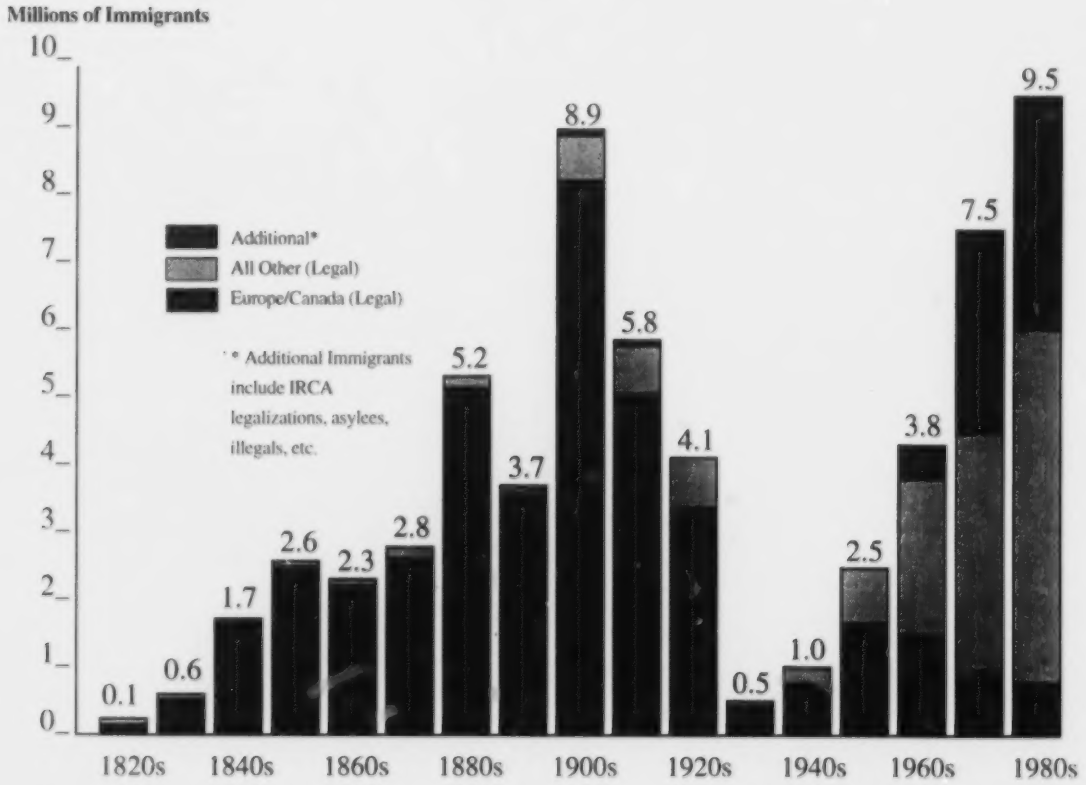


Prepared by the National Conference of State Legislatures from data from the U.S. Department of Health and Human Services

This first wave concluded around the time of World War I, as the United States federal government passed laws restricting immigration and the outbreak of the war made international travel difficult. Thereafter, during the Great Depression and on through World War II, immigration continued, but at greatly reduced levels.

The second major period of immigration to the United States began after the close of World War II, and it continues today. The numbers of immigrants have again grown steadily each decade since the 1940s, reaching 9.5 million between 1981 and 1990. Although the number of immigrants is now at historically high levels, immigrants arriving in the 1980s represented only 3.5 percent of the total United States population. In the early part of this second wave, most immigrants were again Europeans (mostly Germans, English, and Italians) and Canadians. In the 1960s, more non-European immigrants began to arrive. By the end of the 1980s, more than 80 percent of all immigrants were non-European and mostly from Asia and Latin America (see figure 3).

Figure 3
Immigration to the United States by Decade: 1821-1830 Through 1981-1990



Source: INS and The Urban Institute.
Reprinted with permission.

IMMIGRATION STATUS

Before the 20th century, the United States restricted immigration in a piecemeal fashion, excluding limited classes of people (e.g., criminals, paupers, the insane) and ethnic groups (e.g., Chinese and Japanese). At that time, the term "immigrant" was used to encompass all entrants into the United States. However, over the course of this century, immigration restrictions and controls have become more systematic but also more specialized. For example, "legal immigrant" now represents a specific category. The term "newcomer" has replaced "immigrant" to refer to all new arrivals, regardless of their legal status. Therefore "newcomer" includes legal immigrants, refugees, illegal aliens, and all other categories.

Today, permission to enter the United States is based on sometimes conflicting objectives, such as reuniting families while trying to meet United States economic needs or simultaneously promoting United States foreign policy objectives and humanitarian interests. Based on these considerations, the Immigration and Naturalization Service (INS) has created different legal statuses designating the terms of entry. The terms designate the length of residence permitted (temporary or permanent), and whether the applicant may work, apply for citizenship, or receive public benefits. Table 1 presents an overview of immigrants' eligibility for federal benefits. These often complex and varied statuses fall into three general types: legal immigration, humanitarian immigration, and unauthorized immigration (commonly referred to as illegal immigration). The most common legal statuses are described below; other immigrant categories are defined in the glossary (p. 19).

Legal Immigration

Legal immigrants (also "lawful permanent residents" or "permanent resident aliens") are those persons permitted to stay in the country permanently. Lawful permanent residents (LPR) are usually admitted into the United States because they have valuable job skills or family ties to the country. LPR immigrants are eligible to bring family members to reside in the country, to work,

Where They Come From, Where They Go

The majority of legal immigrants in 1991 were from Mexico, Central America, or Asia. Below are lists of the 10 principal countries of origin and the 10 most popular states of intended residence for legal immigrants. In 1991, the top 10 countries of origin accounted for 62.9 percent of all legal immigrants to the United States; the top 10 states of intended residence received 79.1 percent of all legal immigrants to the United States.

Top 10 Countries of Origin	
Soviet Union	56,839
Philippines	55,376
Vietnam	55,278
Mexico	52,866
China	31,699
India	31,165
Dominican Republic	30,177
Korea	21,628
Jamaica	18,025
Iran	18,019
TOTAL	443,292*
	(62.9%)

Top 10 States of Residence	
California	194,317
New York	135,707
Florida	50,897
Texas	42,030
New Jersey	38,529
Illinois	31,633
Massachusetts	19,537
Virginia	16,321
Pennsylvania	14,464
Maryland	13,586*
TOTAL	557,021*
	(79.1%)*

*Figures do not include estimates of illegal immigrants or amnesty immigrants under the 1986 Immigration Reform and Control Act. In 1991, there were 1,123,162 amnesty immigrants, mostly Mexicans, and most of this population settled in California.
Source: Immigration and Naturalization Service

BEST COPY AVAILABLE

Table 1
Overview of Alien Eligibility for Federal Programs

	ALIEN'S STATUS							
Program	**LPR**	**Family Unity**	**Refugee/ Asylee**	**Parolee, Cuban/ Haitian Entrant**	**TPS**	**DED**	**Asylum Applicant**	**Undocu-mented**
CASH								
AFDC	Yes	Same as amnesty alien	Yes	Yes	Yes	Arguably yes as PRUCOL*	No**	No
SSI	Yes	Yes	Yes	Yes	No	Yes	Arguably yes as PRUCOL*	No
Unem-ployment Insurance	Yes	Yes	Yes	Yes	Yes	Yes	Yes (if work-authorized)	No
Refugee Assistance	Yes, if Amer-asian, former refugee or asylee	No	Yes	Yes, if paroled as refugee or asylee or if national of Cuba or Haiti	No	No	No, unless national of Cuba or Haiti	No, unless national of Cuba or Haiti
MEDICAL CARE								
Medicaid	Yes	Same as amnesty alien	Yes	Yes	Emergency services	Yes	Emergency services**	Emergency services
FOOD								
Food Stamps	Yes	Yes	Yes	Yes	No	No	No	No
WIC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
School Lunch and Breakfast	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
EDUCATION								
Headstart K-12	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Title IV Federal Loans	Yes	Yes	Yes	Yes	Arguably Yes	Arguably Yes	Arguably Yes	No
JTPA	Yes	Yes (if work-authorized)	Yes	Yes	Yes (if work-authorized)	Yes (if work-authorized)	Yes (if work-authorized)	No
HOUSING								
Federal Housing	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

*PRUCOL=permanently residing in the U.S. under cover of law
**Some states, such as Florida and Massachusetts, recognize as PRUCOL.

LPR=Lawful Permanent Resident
TPS=Temporary Protected Status
DED=Deferred Enforced Departure

Table prepared by the National Immigration Law Center 9/93

and to apply for United States citizenship after five years of continuous residence in the United States. Lawful permanent residents are eligible to apply for all federal assistance programs.

Humanitarian Immigration

Refugees are those persons outside their country of origin but not yet in the United States who have a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. Refugees are eligible to work in the United States upon entry and may convert to permanent resident status after one year of residence in the country. Refugees are eligible to apply for any federal assistance program. Additionally, some needy refugees qualify for a refugee-specific, federal income assistance and medical program.

Asylees are refugees who are already present in the United States at the time they apply for refugee protection. They are eligible for the same benefits as refugees, but only 10,000 may become lawful permanent residents each year.

Parolees are persons who normally would not be admissible but are allowed to enter temporarily for humanitarian, medical, and legal reasons. Unlike refugees, parolees are not eligible for special federal benefits nor are they on a predetermined path to permanent resident status. Some parolees qualify for work authorization, depending on their personal circumstances.

Unauthorized Immigration

Legalized aliens (also called amnesty aliens or "pre-82s") are former unauthorized, or illegal, aliens who were given legal status under the Immigration Reform and Control Act (IRCA) of 1986. To qualify, unauthorized aliens had to prove they had resided in the United States since 1982 or that they were qualifying special agricultural workers (SAWs). These unauthorized persons were awarded a one-time opportunity to become lawful permanent residents. After earning lawful permanent residence, legalized aliens are permitted to apply for citizenship. Legalized aliens are barred from most federal government assistance programs for five years from the date of their legalization, but they are permitted to work immediately.

Unauthorized migrants (also undocumented or illegal aliens) are persons present in the United States without permission of the government, either by illegally crossing the border or overstaying the permitted time on their immigration documents. Unauthorized persons are not permitted to access most federal government programs or apply for citizenship.

THE NEWCOMER IN THE 1990S

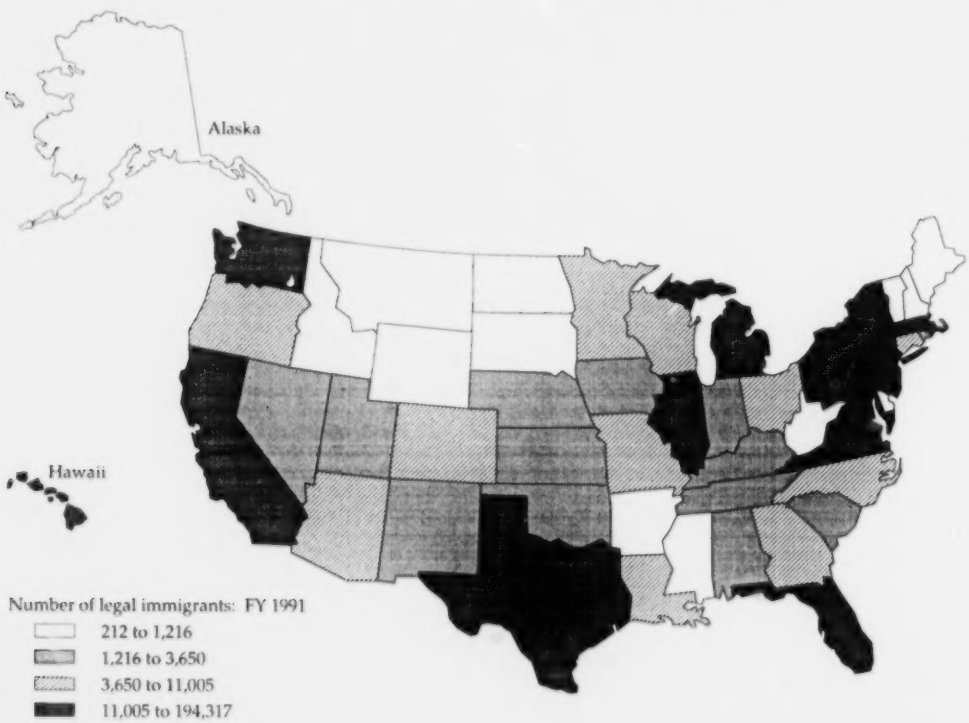
In 1991, 1,827,167 persons were granted lawful permanent resident status. However, it should be noted that this total is abnormally high because it includes aliens granted lawful permanent residence status under the 1986 IRCA amnesty program. There were 1,123,162 legalized aliens granted LPR status in 1991, leaving a total of 704,005 normal admissions for the year (see figure 4). In recent years there have been more female immigrants than males. In 1991 this trend was reversed; male immigrants represented 66.4 percent of the total immigrant population while females represented

The Visa	The "Green Card"
Essentially, a visa is a ticket to enter the United States, usually in the form of a stamp (in a passport) or a card. Visas are issued by the Department of State. There are two kinds of visa: a nonimmigrant visa, which grants its possessor temporary permission to stay in the country, and a permanent residence, or immigrant, visa, which confers lawful permanent residence status on its holder.	After legal immigrants enter the United States, with their immigrant visas, they are issued a "green card" (now actually pink), also called a resident alien card. This card is proof of lawful permanent residence in the United States and it authorizes the recipient to work in the country. Green cards are issued by the INS to legal immigrants after their arrival and to refugees after one year of residence. Other aliens are eligible to apply for green cards subject to the limitations of their specific legal status.

33.6 percent. The median age for all immigrants in 1991 was approximately 29 years. However, these data are also affected by the IRCA amnesty program. Amnesty immigrants are overwhelmingly male and are older than the normal immigrant population.

Immigrants in the 1990s are the most diverse population ever to come to the United States. They bring widely divergent experiences and skills to this country. Many come to the United States with education and job skills, and quickly become economic contributors as scientists, engineers, artists, entrepreneurs and athletes. Other immigrants, however, face a broad range of problems and barriers to successful participation in American society. For example, one-third of immigrant workers are high school dropouts and therefore may have limited English skills or be illiterate in their own languages. Refugees have often been psychologically and physically tortured in "re-education camps" before leaving their home countries. Elderly immigrants often have few marketable skills and poor health, which make self-sufficiency an elusive goal. Unauthorized persons sometimes avoid reporting crimes to the police because they fear deportation, but this may make them easy targets for discrimination and extortion. This diversity requires flexibility on the part of state and local policymakers to help newcomers become self-sufficient members of the community.

Figure 4
Legal Immigration to the United States in FY 1991



Note: Data do not include the 1986 ICRA amnesty population and are presented according to the immigrant's state of intended residence. Total non-IRCA immigration is 1,123,162.
Source: Statistics Division, Immigration and Naturalization Service

Federal Administration

The federal government plays three roles in the immigration and immigrant policy dynamic that concern states and localities: (1) regulating admissions into the United States; (2) funding resettlement assistance for very limited and specific groups of newcomers (i.e., refugees and legalized aliens); and (3) determining newcomer eligibility for federal programs.

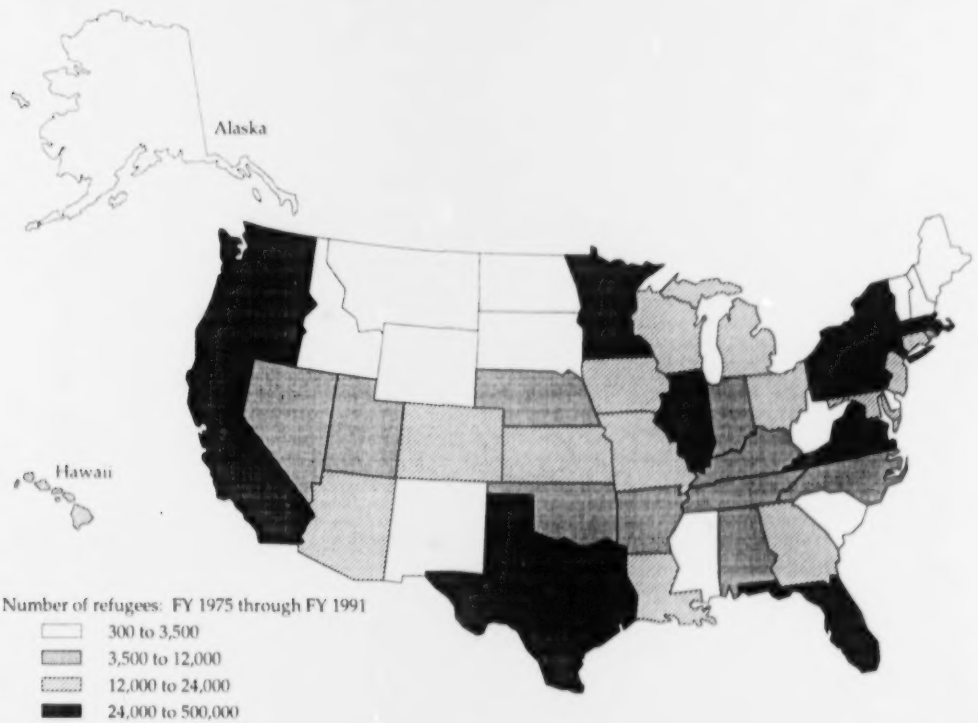
The federal responsibility for immigration is shared by the President, four executive departments (State, Justice, Health and Human Services, and Labor), and Congress.

The **President** is responsible for setting admission levels for refugees, in annual consultation with Congress (usually a meeting between the U.S. coordinator for refugee affairs and the House and Senate judiciary committees).

The **Department of State** administers immigrant and nonimmigrant visas, and its **Bureau for Refugee Programs** handles overseas refugee assistance to prepare refugees to enter the country.

The **Immigration and Naturalization Service (INS)** of the **Department of Justice (DOJ)** is responsible for processing applications for immigration and citizenship, inspecting aliens for admission to the United States and enforcing the nation's immigration law. DOJ's **Executive Office for Immigration Review (EOIR)** is the judicial locus of admissions oversight. The EOIR consists of the immigration judges who adjudicate immigration law, and the **Board of Immigration Appeals (BOIA)**, which hears immigrant appeals to immigration judges' decisions. The **Community**

Figure 5
Cumulative Refugee Arrivals, FY 1975 through FY 1991



Source: Office of Refugee Resettlement, U.S. Department of Health and Human Services; and Ron Spendal, Oregon Refugee Coordinator

Relations Service (CRS) provides limited resettlement assistance for Cuban/Haitian entrants allowed into the United States.)

The **Department of Health and Human Services**, through the **Office of Refugee Resettlement** and its **Division of State Legalization Assistance**, is responsible for administering federal reimbursement to states and localities for expenditures made on behalf of refugees and legalized aliens.

The **Department of Labor's Employment and Training Administration** is responsible for coordinating international migration with domestic workforce needs.

In **Congress**, the **House and Senate Judiciary Committees** have jurisdiction over immigration, citizenship, and refugee policy issues. The **House and Senate Appropriations Committees** oversee domestic and overseas program funding. Additionally, Congress periodically creates various task forces and commissions to study immigration. Currently one commission is operating, the **Commission on Immigration Reform**.

Judicial Mandates

The courts play a part in shaping newcomer benefit eligibility. Judicial decisions have required states and localities to allow certain groups of aliens to participate in a number of specified state and locally funded programs. For example, in the 1971 case of *Graham v. Richardson*, the United States Supreme Court ruled that state welfare benefits may not be denied to aliens. In the 1982 case *Plyler v. Doe*, the U.S. Supreme Court found that undocumented children are entitled to equal protection under the law and therefore must be allowed to enroll in public education. Finally, in 1992 the U.S. District Court decided in *Lewis v. Grinker* that pregnant women are eligible for prenatal care under Medicaid regardless of their immigration status. Although the ruling affects New York state immediately, it is not clear whether this decision can be applied to prenatal care in other states. California is likely to be the first testing ground for the applicability of *Lewis* outside of New York as immigrant advocates in California are suing the state on these grounds.

State and Local Administration

State and local governments have a de jure responsibility for getting special resettlement services and assistance to qualifying newcomers as a result of federal law. Typically, states and localities meet this responsibility by either providing services through their own mainstream social services offices or by contracting with nongovernmental organizations and coordinating their efforts. This assistance is either first paid for by states and localities, which are in turn reimbursed by the federal government (e.g., the State Legalization Impact Assistance Grant) or paid for up front by the federal government (e.g., refugee assistance).

States and localities also have a legal responsibility to provide certain judicially mandated services to the newcomer population. The costs of these services are not reimbursed by the federal government but are paid for solely with state and local government tax revenue.

Finally, states and localities have a de facto responsibility to assist newcomers who do not qualify for special federal resettlement assistance, thus serving as a safety net of last resort. New-

Newcomer Tax Revenue: A Federal Monopoly

Paying for immigrant resettlement is difficult for state and local government. Although newcomers pay a great deal in taxes ($90 billion annually, by at least one national estimate), nearly two-thirds of these taxes are paid to the federal government through the income and Social Security taxes while only one-third is paid to state or local governments. Despite this incongruity, in recent years federal resettlement assistance has declined (see figures 1 and 2), and states and localities have been forced to pay more for resettlement needs. Concomitantly, the federal government has not provided sufficient funding to states and localities for newcomer resettlement for the levels of newcomers it admits. The result is high levels of admissions but inadequate funding for resettlement and no relief for state and local budgets. The federal government receives most of the immigrant revenue, and the states and localities provide most of the services.

comers outside the purview of federal resettlement assistance participate in state-local and state-federal medical, social service, and income assistance programs (i.e., state-local programs such as general assistance, state Medicaid, indigent health care and state-federal programs such as Aid to Families with Dependent Children [AFDC], Supplemental Security Income [SSI] and Medicaid/Medicare). States and localities are not reimbursed for the costs for newcomers participating in either state-local programs or the state portion of state-federal matching grant programs. As federal assistance continues to decline, the de facto responsibility of states and localities increases. (As part of the Immigrant Policy Project, the American Public Welfare Association and the Urban Institute collaborated on a survey to assess the effects on programs, services, and institutional capacity of funding delays and cutbacks in federal programs serving refugees and the newly legalized. The results of the survey are reported in chapter 5.)

States and localities have responded to this crisis by creating offices to serve immigrant needs. For example, the mayor of New York City has created an Office of Immigrant Affairs and Texas and Massachusetts have created similar statewide offices. As part of their oversight responsibility, state legislatures in California, Virginia, and New York created a committee, a subcommittee and a task force, respectively, to study newcomer issues. Additionally, according to federal law each state must have a refugee coordinator to ensure the coordination of public and private resettlement resources, and a SLIAG administrator to coordinate resources for the newly legalized population.

Nongovernmental Organizations

The private sector plays a vital role in resettling newcomers. Refugee resettlement assistance and services are provided by a network of private voluntary resettlement agencies (VOLAGs), mutual assistance associations (MAAs), and state and local governments. Generally, states and localities contract with VOLAGs and MAAs to provide initial services to refugees. State governments occasionally provide services directly. For example, the state of Iowa serves both as a voluntary agency for reception and placement and as the state's social service provider. The state of Vermont has affiliated with a voluntary agency to provide joint services to newcomers resettling in that state.

Resettlement assistance for newly legalized aliens is delivered through a similar, although less institutionalized, network. This network is made up of community-based organizations (CBOs), local school districts, state universities and community colleges, local indigent health care providers, and state-subsidized hospitals. Some states have used SLIAG money to actually fund the creation of community organizations that provide education and health services to the newly legalized population.

VOLAGs and MAAs

A VOLAG (voluntary agency) is usually a nonprofit organization, often affiliated with a religious organization, the provides the initial reception and placement of refugees in the United States. Approximately 10-12 voluntary agencies (including the state of Iowa which serves as a VOLAG) have cooperative agreements with the Department of State to provide services during refugees' first 90 days in the United States. Additionally, five voluntary agencies currently participate in the matching grant program of the Department of Health and Human Services to provide resettlement services for eight months after the initial reception and placement.

MAAs (mutual assistance associations) are nonprofit organizations, created by and for specific ethnic groups, that provide resettlement assistance to refugees. MAAs also receive federal grant money to provide resettlement services to newly arrived refugees.

Federal Immigration Law

Foreigners can enter the United States with the intent to stay permanently or temporarily. Those entering with the intent to reside permanently can be (1) legal immigrants, (2) humanitarian immigrants, or (3) unauthorized migrants. (Humanitarian immigration is not a legal category or status but is used broadly to include those immigrants allowed to enter for humanitarian reasons: refugees, asylees, parolees, etc.)

Foreigners can also enter the country temporarily as (1) nonimmigrants, who enter each year as tourists,

students, and other temporary visitors, or (2) unauthorized persons, such as day workers or family members who come for short visits to the United States.

The following sections describe the laws that govern legal immigration, humanitarian immigration, legalization, and unauthorized entry and the effects they are having on state and local governments. Congress passed three major pieces of legislation amending the Immigration and Nationality Act, the basic immigration code of the United States, during the 1980s: the Immigration Act of 1990, the Refugee Act of 1980, and the Immigration Reform and Control Act of 1986.

Legal Immigration and the Immigration Act of 1990

The most common method of obtaining long-term residence in the United States is to apply for legal immigration and the accompanying lawful permanent resident status. In 1990, Congress conducted a comprehensive overhaul of the Immigration and Nationality Act, the basic immigration code of the United States. The Immigration Act of 1990 (P.L. 101-649) altered the process for legal immigration and increased the number of visas for legal immigration from 570,000 to 700,000. In FY 1995, the number of available visas will decrease to 675,000 visas per year for legal immigrants.

The 1990 act created a new preference system to distribute visas. It identifies three categories of legal immigration and divides the 675,000 visas among them: 480,000 (71 percent) to immigrants related to United States citizens and permanent resident aliens, 140,000 (21 percent) to specially skilled (or employment-based) immigrants, and 55,000 (8 percent) visas to what are called "diversity" immigrants from countries awarded few visas the previous five years. (See box "Priorities for Distributing Legal Immigration Visas.")

Family-related immigrants are of two types: immediate relatives (i.e., spouses; minor, single children; parents of adult United States citizens) and family-sponsored immigrants (adult children and brothers and sisters of United States citizens; spouses and unmarried children of permanent residents). Family-sponsored immigrant visas were capped under the 1990 act for the first time.

Employment-based immigrants are those aliens with extraordinary ability, advanced degrees, special skills, or professional experience. Others eligible under this category are religious workers, unskilled laborers, and persons investing at least $1 million in the United States that will create at least 10 new jobs.

"Diversity" immigrants are persons from those countries that received less than 50,000 visas over the preceding five years. Most diversity immigrants will likely come from Europe, because during the 1970s and 1980s few visas were set aside for, or awarded to, European immigrants. To be eligible, aliens must have the equivalent of a high school education or two years of work experience.

The 1990 act also created a new legal status for humanitarian immigrants. The United States attorney general may now award "temporary protected status" (TPS) eligibility to nationals from countries faced with natural or man-made disasters who may remain in the United States until their countries are deemed safe. Examples of countries whose nationals have received TPS are Kuwait, El Salvador, Lebanon, Liberia, and Somalia.

Exclusion and Deportation

Not everyone who wishes to enter the United States is permitted to do so. Many foreigners who want visas are denied them by U.S. immigration law. However, even certain people with visas are prevented (i.e., "excluded") from entering the country based on criteria established in United States immigration law. These criteria include infection with AIDS, a history of criminal activity, or a likelihood of violating the terms of entry.

Similarly, some people already in the United States may be forced to leave (i.e., "deported") if they violate certain conditions listed in United States immigration law. Newcomers can be deported for a number of reasons, such as violating the conditions of their entry visa (e.g., overstaying their approved length of time), committing a crime, becoming a public charge (i.e., becoming dependent on government assistance), or entering the country without inspection (i.e., illegally).

Priorities for Distributing Legal Immigration Visas

Immediate Relative Immigrants—Unlimited

There are an unlimited number of visas available to immediate family relatives of United States citizens. Immediate family members include the following: spouses, minor and single children, and parents.

Family-Sponsored Immigrants—Minimum of 226,000 Visas

Because the cap on family-related immigration is 480,000 and immigration by immediate relatives of citizens (see above) is unlimited, it is conceivable that immediate relatives might use up all 480,000 visas in a given year. To protect other family members from this occurrence, at least 226,000 visas every year are available to people in the family-sponsored category, thereby making the 480,000 figure a "pierceable cap." If more than 480,000 visas are awarded to family members in a given year the difference between the two numbers is subtracted from the family-sponsored category in the following year.

1) Unmarried sons and daughters of United States citizens 23,400/year
2) Spouses and unmarried sons and daughters of permanent residents 114,200/year
3) Married sons and daughters of United States citizens 23,400/year
4) Brothers and sisters of adult United States citizens 65,000/year

Employment-Based Immigrants—140,000 Visas

1) Aliens with outstanding abilities 40,000/year
2) Aliens with advanced degrees or with exceptional abilities requiring labor certification 40,000/year
3) Aliens with needed skills, unskilled workers of whom there is a shortage, or aliens with baccalaureate degrees, all requiring labor certification 40,000/year
4) Special immigrants, including religious workers 10,000/year
5) Foreign investors willing to invest $1 million to create at least 10 jobs 10,000/year

The Immigration Act of 1990 also sets aside a number of visas between FY 1992 and FY 1994 to allow the family members of newly legalized aliens to obtain lawful permanent residence in the United States. To qualify, family members must prove that they have resided in the country since May 1988.

The 1990 act also increased the number of asylees who could obtain LPR status from 5,000 to 10,000 per year and created an emergency immigration fund.

State and local impact. Legal immigrants may participate in any federal, state, or local program for which they meet the categorical eligibility requirements. The federal government and most states and localities do not track public benefit recipients by their immigration status, and therefore the specific cost of serving newcomers in these programs is, for the most part, unknown. However, it is evident that immigrants make extensive use of some specific programs.

For example, education services are widely used by both youth (e.g., K-12) and adults. This is partly because immigrants are entitled to public education, and immigrant families are younger than average, and therefore are more likely to have school-age children. Education is paid for by state and local governments, but these costs are not completely recovered from immigrant tax revenue. Additionally, federal education programs for immigrants are being reduced, putting further pressure on states and localities. For example, funding for the Immigrant Education Act, the only impact aid for immigrant education, fell by half over the course of the 1980s. Similarly, funding for Title VII bilingual education for limited English proficient children fell by half over the 1980s.

Finally, the Refugee Education Assistance program has been unfunded since 1988.

In contrast, legal immigrants are unlikely to access welfare and income assistance programs unless absolutely necessary for a number of reasons. First, the great majority of immigrants come to the United States to work. Second, legal immigrants with sponsors are ineligible for AFDC, SSI, and food stamps for three years (see box "Three-Year Deeming and Public Charge"). Also, immigrants may worry that if they use welfare they might be designated a "public charge" and then be deported. Finally, many immigrants are from cultures that encourage individuals to depend on their families instead of the government or other resources.

Humanitarian Immigration and the Refugee Act of 1980

One of the nation's founding principles has been the offer of freedom and opportunity to the oppressed, perhaps best symbolized by the Statue of Liberty and its promise of asylum. Before 1980, humanitarian assistance was provided in a piecemeal fashion, assisting only limited classes of people (e.g., Cubans and Indochinese). In 1980, the nation extended its humanitarian commitment by establishing a comprehensive, national refugee resettlement and assistance policy. The Refugee Act of 1980 provided a definition of "refugee" consistent with international law and established a framework for the selection of refugees for admission to the United States. This policy was intended to replace the former ad hoc, discretionary parole authority of the 1952 Immigration and Nationality Act and the conditional entrant preference established by the 1965 Amendments to the act.

Of the four main humanitarian categories (refugee, asylum, parole, and temporary protected status), the refugee group is historically the largest (approximately 123,000 in FY 1992). However, the continued use of parole permits large numbers of "refugee-like" persons (approximately 137,000 in FY 1992) to enter. Data indicate that since temporary protected status was created in 1990, more than 200,000 persons have been awarded permission to stay in the United States temporarily. Finally, in FY 1992, more than 5,000 persons were granted asylum, and more than 103,000 applications for asylum were filed.

Three Year "Deeming" and "Public Charge"

Some legal immigrants come to the United States with the aid of citizens who serve as their "sponsors." A sponsor is someone who files an "affidavit of support" to help the sponsored immigrant obtain lawful permanent resident status. As a result of this relationship, the federal government requires any sponsored immigrant to include the sponsor's resources in any application for AFDC, SSI, food stamps, and a few state general assistance programs for their first three years in the United States. The sponsor's income is therefore "deemed" available to the sponsored immigrant. However, the affidavit does not legally obligate sponsors to share their resources with the sponsorees.

The federal government expects newcomers to become self-sufficient as soon as possible after their arrival. Immigrants who become dependent upon public assistance (state, federal, or both), fail to find employment, and are unlikely to be self-supporting in the future (because of poor health, inadequate education, lack of sponsorship, etc.) may be deported on the grounds that they have become a "public charge." The "public charge" issue usually affects aliens trying to obtain LPR status and rarely affects lawful permanent residents.

According to the Refugee Act of 1980, the President must set an annual ceiling on the total number of refugees that may enter the United States. Also, separate regional ceilings must be set, limiting the number of refugees from each part of the globe. Once applications have been received, the Department of State's Bureau of Refugee Programs applies a priority system to decide which persons will be selected for entrance (see box "Priorities for Admitting Refugees").

Newcomers needing humanitarian safe haven often need help in making a successful transition into American society. Vietnamese refugees have sometimes experienced persecution in their native land, including physical and psychological torture. Some Latino parolees know little English and have few marketable job skills. Other humanitarian

immigrants, like the Hmong are from primitive cultures and therefore need orientation to modern technology and amenities. With such overwhelming barriers to successful assimilation, humanitarian immigrants are a very vulnerable population. The federal government recognized the tremendous need of humanitarian immigrants and its own responsibility for meeting these needs in the Refugee Act of 1980.

Priorities for Admitting Refugees

The Refugee Act of 1980 established the following criteria for determining which refugees have priority in entering the United States:

Priority 1 Those in immediate danger of loss of life (e.g., political prisoners)

Priority 2 Former employees of the United States government for one or more years

Priority 3 Persons with a close United States family relation (spouse, unmarried child, or parents of persons legally in the country)

Priority 4 Those with close ties to United States foundations, voluntary agencies, or United States companies for one or more years

Priority 5 Relatives who do not fit in category three

Priority 6 Those whose admission is in the national interest of the United States because of their nationality

The Refugee Act authorized and codified, for the first time, federal assistance for comprehensive, domestic resettlement of refugees. It provided for reimbursement to states for the cost of providing cash and medical assistance to all refugees up to a maximum of their first three years in the United States. This Cash and Medical Assistance program (CMA) originally covered all state costs for refugees who meet the requirements for "categorical" programs: AFDC, SSI, Medicaid, and state-financed General Assistance programs. The act also reimbursed states through CMA for refugees who were needy but who did not qualify for categorical programs, through a parallel program of Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA).

The Office of Refugee Resettlement provides resettlement assistance to refugees, asylees, Cuban/Haitian entrants, and Amerasians under the following programs:

- **Social Services** is a federal grant to states to provide English language training and employment services and Title XX services such as translation, orientation, day care, and transportation for refugees in the United States for three years or less. When a state has a "cash assistance dependency rate" for refugees of 55 percent or more, ORR regulations require the state to spend 85 percent of their Social Services funds on employability services. States may request a waiver of this requirement.

- The **Targeted Assistance Grant** is additional federal assistance to those communities that receive the most eligible refugees and Cuban/Haitian entrants.

- The **Preventive Health Services** program provides grants to state public health facilities to perform health screening and follow-up treatment.

- The **Voluntary Agency Matching Grant** provides matching funds to voluntary resettlement agencies that assist in refugee resettlement.

State and local impact. As the federal budget problems have increased, funding for the refugee resettlement program repeatedly has been cut back (see figures 1 and 2). Since 1981, federal reimbursement for the costs incurred by serving the AFDC-eligible population has decreased from 36 months to no reimbursement at all. States and localities now pay for this group just as they pay for the cost of services to legal immigrants. Similarly, since 1981 federal reimbursement for RCA and RMA has dropped from 36 months of reimbursement to eight months.

Second, some humanitarian immigrants do not qualify for federal income-maintenance programs or resettlement assistance. Parolees do not qualify for the Refugee Act benefits, neither do newcomers with temporary protected status. There is no limit

on the number of parolees that INS may admit each year. States and localities bear the cost of providing services to these populations by the default of the federal government, even though these immigrants have many of the same needs of the refugees, asylees, and Cuban/Haitian entrants who receive federal assistance.

Illegal Immigration and the Immigration Reform and Control Act of 1986

There are a number of ways in which unauthorized persons enter the United States. Some stow away on vehicles entering the United States. Others cross the 1,951-mile-long border by themselves or with the aid of "coyotes," smugglers who arrange to get foreigners into the country in exchange for money. Some newcomers originally obtain legal permission to enter but then overstay the time of residence provided for in their visas. Still others use forged documents to enter the country.

During the 1980s, the number of persons in the United States without legal permission increased rapidly because jobs and wages were much more attractive in the United States than in most other countries. Many others wanted to be reunited with family members already living in the United States. It is estimated that in 1980, between two million and four million unauthorized people were in the United States. By 1986, it was believed that the number had increased to between three million and five million people.

In 1986, the Immigration Reform and Control Act (IRCA) was passed to address this rise in illegal immigration. It established employer sanctions (fines and jail sentencing) for hiring unauthorized workers and provided a one-time amnesty to allow unauthorized migrants currently residing in the United States to apply for legalization. IRCA granted amnesty to 2.6 million unauthorized aliens who had lived in the United States since 1982 ("pre-82s") or had performed special agricultural work ("SAWs"). Pending some remaining SAW applications, an additional 100,000 aliens may be authorized. However, like the humanitarian newcomers, the newly legalized were in great need of language training, health care, education, and other social services. And, as before, at first the federal government recognized its responsibility to pay for this resettlement assistance.

To minimize the impact on United States taxpayers and to prevent the reduction of benefits to disadvantaged citizens, the amnesty aliens were temporarily denied access to federal programs based on financial need (specifically AFDC, Medicaid, and food stamps). The State Legalization Impact Assistance Grant (SLIAG) program was created to reimburse states for the expenses they would incur by serving this population during the five-year exclusion period. SLIAG provides federal reimbursement to states for costs incurred for public assistance, public health, and education. Public assistance primarily includes the state share of Medicaid and hospital and medical care for the amnesty immigrants. The public health programs include immunization, testing, family planning, and preventive health screening. Educational services consist mainly of instruction in basic English, American government and history, and citizenship. Vocational training is not covered under the SLIAG program.

The IRCA legislation also increased border enforcement and created the Systematic Alien Verification for Entitlements (SAVE) system. SAVE requires state and federal benefit-granting agencies to verify that alien applicants for specific federal benefits (AFDC, Medicaid, food stamps, unemployment insurance, education loans and grants, and housing) have the authorized legal status for participation in these programs. Additionally, IRCA grants lawful permanent resident status to Cubans and Haitians who entered before 1982.

State and local impact. The good intentions that IRCA represented have evaporated. The federal government has not been forthcoming with the aid it promised in the program's authorizing legislation. SLIAG was created as a four-year, $4 billion program, with a seven-year spending cycle, designed to allow for the anticipated higher demand for assistance in the later years of the program. States were permitted to spend the 1988-1991 appropriations until 1994. However, beginning in 1990, large portions of the promised SLIAG appropriations were deferred to later fiscal years. States were finally paid the $812 million owed them in FY 1994.

Second, the five-year exclusion from federal assistance is ending for those who qualified for the amnesty program in its first year 1987-1988. Therefore, there will likely be increasing caseloads in the AFDC, SSI, food stamps, and Medicaid programs and a corresponding increasing state matching grant requirement for state governments.

Third, despite IRCA's early success in reducing illegal entries, it is estimated that the number of unauthorized migrants is increasing again. One measure often used in estimating illegal entries is the number of apprehensions reported by the Border Patrol. Some increase this number to account for entrants who successfully elude the Border Patrol. Others adjust the number down, noting that aliens continue to cross the border until they are successful in gaining entry, despite the fact that they may be apprehended by the Border Patrol many times, thereby inflating estimates of unauthorized immigration. In fact, unauthorized aliens are often commuters who return to their native countries when they have earned some money, have completed work or cannot find any, or miss their families; these returns are not counted. Accounting for these factors, the Urban Institute estimates that the net annual flow of unauthorized migrants intending to reside permanently in the United States is roughly 200,000. The INS in October 1992 estimated the total resident illegal population in the United States at 3.2 million.

Finally, the IRCA employer sanctions have proved problematic. The GAO has found that employers are discriminating against legal minority residents for fear of violating the IRCA sanctions. Members of the business community have complained that a black market of fraudulent Social Security cards and drivers' licenses makes compliance difficult. As a result, there have been a number of congressional attempts to eliminate employer sanctions, none of which have been successful. Other members of Congress are interested in creating tamper proof documents and improving the employment eligibility verification system.

Conclusion

The 1980s showed the highest levels of immigration in the United States since the turn of the century. Even if recent immigration trends were suddenly reversed, the diversity of ethnicity and race of these recent arrivals will have lasting effects on our public institutions and will create new challenges for state and local officials. How will health and social service programs adjust to a multilingual, multicultural population? How will school systems adapt to the needs of children from 100 different countries? How can state and local officials ensure that public services and benefits are distributed equitably among the members of the community?

Although the federal government has exclusive jurisdiction over immigration, there is a lack of responsibility for immigrants after their arrival. Federal resettlement programs are piecemeal and inadequate. Though more immigrants are arriving, funding has been reduced or constrained for the few programs that assist new immigrants to integrate into the economic, social, and civic life of the United States.

In the absence of a comprehensive federal policy to provide for refugees and immigrants, state and local governments are creating immigrant policy. States and localities implement programs required by federal law, provide services mandated by the courts, and initiate programs and policies to serve the specialized needs of their new citizens.

The number and diversity of the new immigrants are creating new fiscal and social challenges for state and local governments. The lack of a comprehensive federal policy is compelling state and local government to create immigrant policy, but without adequate resources. Many state and local governments are grappling with continuing budget deficits. Although immigrants are valuable contributors to the U.S. economy and pay taxes ($90 billion according to one estimate), there is inequity in the flow of immigrant revenues. Economists show that two-thirds of revenues provided by immigrants flow to the federal level, while only one-third flows to states and localities. Yet the needs of the new arrivals cause states and localities to incur significant costs, particularly for education and health care. This disparity leads to unreimbursed costs for state and local governments.

We have yet to see what immigration and refugee policy will be for the 1990s. It is likely that the new administration and Congress will re-examine immigration laws and consider a restructuring of the refugee program. Immigration reform should include the following components: (1) program planning and implementation at the community level to address service needs and community relations and (2) a redress of the fiscal inequity of immigrant revenues and costs among the federal, state, and local levels.

The following immigrant categories and legal statuses are also among the most numerous and frequently used newcomer categories. Other categories are defined on pages 6 and 7.

Amerasians are Southeast Asian children fathered by United States citizens and born in Southeast Asia. Amerasians are eligible to emigrate to the United States under various immigration laws. Spouses, children, parents, or guardians may accompany the immigrating Amerasian.

Cuban/Haitian entrants are in the "entrant" category (legal status pending) which was originally created for the Cuban and Haitian arrivals of 1980 and allowed for this population to obtain work permits and to apply for public assistance. Title V of the Refugee Assistance Act of 1980 extended eligibility for refugee services to this population and to future Cuban/Haitian arrivals in temporary status as a parolee, asylum applicant, etc.

Deferred enforced departure (DED) status is awarded to immigrants at the discretion of the executive branch. It awards work authorization and temporary protection from deportation to its recipients. It has been granted only to El Salvadorans and Chinese students after the events of Tiananmen Square.

Family unity entrants are immediate family members of legalized aliens. These persons must have lived in the United States since May 1988. Family unity entrants are granted a stay of deportation and permitted to work in the United States; they receive the same public benefits as the legalized alien family member.

Naturalization is the process by which a foreign-born individual becomes a citizen of the United States. Naturalization requires that the person be over 18 years old, lawfully admitted to the United States, reside in the country continuously for five years, and have a basic knowledge of English and American government and history.

Nonimmigrants are temporary visitors to the United States who are allowed to enter the country for specific periods of time with nonimmigrant visas. Examples of nonimmigrants are students, tourists, and business travelers. They are typically ineligible for public benefits, but certain categories may obtain authorization to work while in nonimmigrant status.

The ***permanently residing under color of law*** (PRUCOL) status is a legal term that applies to "aliens here (in the United States) under statutory authority and those effectively allowed to remain here under administrative discretion." PRUCOL status means that an alien is considered to be legally residing in the country for an indefinite period for the purposes of determining benefit eligibility for public assistance. PRUCOL is not a method of entering the United States and applies only to public benefit eligibility, and therefore it is not a legal, or immigration, status like lawful permanent resident or refugee.

Temporary protected status (TPS) aliens are authorized to stay in the United States for a specified limited time, during which they are eligible to work and live in the country. After the time period expires, either their status may be extended, or they may be required to leave the country. Like asylum, TPS is granted only to those already in the country. TPS is awarded to whole classes of people, such as Lebanese or El Salvadoran nationals, so that they can escape civil unrest in their native countries.

Voluntary departure status can be awarded by an immigration judge to a newcomer in deportation proceedings. The newcomer must have no criminal history, agree to voluntarily leave the country, and prove he or she has the financial means to do so.

Extended voluntary departure (EVD) status is a grant of additional time to voluntarily leave the country.

REFERENCES

Cose, Ellis. *A Nation of Strangers: Prejudice, Politics and the Populating of America*. New York: William Morrow and Co., Inc. 1992.

Defreitas, Gregory. "Hispanic Immigration and Labor Market Segmentation." *Industrial Relations*, vol. 27 no. 2, Spring 1988.

Fix, Michael, and Jeffrey S. Passel. *The Door Remains Open: Recent Immigration to the United States and a Preliminary Analysis of the Immigration Act of 1990*. PRIP-UI-14. Washington, D.C.: The Urban Institute, Program for Research on Immigration Policy, January 1991.

Griffin, Rodman D. "Illegal Immigration: Does It Damage the Economy and Strain Social Services?" *CQResearcher*, April 24, 1992, 361-384.

Gurwitt, Rob, "Back to the Melting Pot." *Governing*, June 1992, 31-35.

Keely, Charles B. *American Immigration - The Continuing Trends*. New York: The Coordinating Committee for Ellis Island, Inc., 1989.

Kilborn, Peter T. "Law is Said to Fail to Stop the Abuse of Farm Workers." *The New York Times*. October 22, 1992, A1.

Mandel, Michael J., and Christopher Farrell. "The Immigrants." *Business Week*, July 13, 1992, 114-122.

Mason, Jana. "Immigration Act of 1990." *W Memo*, April 1991, 15-25.

Morosoff, Ellen. *Immigration Policy and the Labor Force in New York State*. Albany: New York State Legislative Commission on Skills Development and Vocational Education, October 1991.

Morse, Ann. "United States Immigration and Refugee Policy: Federal Policy and Its Impact on States." *State-Federal Issue Brief*, vol. 3, no. 2, Denver: National Conference of State Legislatures, June 1991

Muller, Thomas. *The Fourth Wave: California's Newest Immigrants*. Washington, D.C.: The Urban Institute Press, Spring 1984.

North, David S. *IRCA Did Not Do Much to the Labor Market: A Los Angeles County Case Study*. Working Paper no. 10. United States Department of Labor, Division of Immigration Policy and Research, International Labor Affairs Bureau, November 1991.

Rosenberg, David E. "Serving America's Newcomers: States and Localities Are Taking the Lead in the Absence of a Comprehensive National Policy." *Public Welfare*, Winter 1991, 28-37.

Stanfield, Rochelle L. "Melting Pot Economics." *National Journal*, February 22, 1992, 442-446.

U.S. Department of Health and Human Services, Office of Refugee Resettlement. *Refugee Resettlement Program: Annual Report to Congress, FY 1991*, January 31, 1992.

U.S. Department of Labor, Bureau of Labor Affairs. *The Effects of Immigration on the United States Labor Economy and Labor Market*. Immigration Policy and Research Report no. 1, January 1989.

U.S. General Accounting Office. *Refugee Resettlement: Federal Support to the States Has Declined*. GAO/HRD-91-51. December 1990.

U.S. General Accounting Office. *Immigration Reform: Employer Sanctions and the Question of Discrimination*. GAO/GGD-90-62. March 1990.

U.S. Immigration and Naturalization Service. *Statistical Yearbook of the Immigration and Naturalization Service, 1991*. Washington, D.C.: Government Printing Office, September 1992.

Vialet, Joyce C. "A Brief History of United States Immigration Policy." *CRS Report for Congress*. Washington, D.C.: Congressional Research Service, January 25, 1991.

Weissbrodt, David. *Immigration Law and Procedure* 2nd Ed. In a Nutshell Series. St. Paul, Minn.: West Publishing Co., 1989.

Wheeler, Charles, and Rebecca Chiao. *Guide to Alien Eligibility for Federal Programs*. Los Angeles: National Immigration Law Center, 1992.

2. Health Care Issues for New Americans

Jonathan C. Dunlap
Fay Hutchinson
National Conference of State Legislatures

Chapter 2 was originally published as America's Newcomers: Health Care Issues for New Americans *by the National Conference of State Legislatures, July 1993.*

Introduction

Over the past year, health care reform has become a top priority on the country's domestic agenda. Immigrants and refugees are among the millions of people who are currently without health insurance, who are insured only part of the year, or who have health insurance that is inadequate to meet their needs in the event of a catastrophic illness. The demand for newcomer health care services continues to eclipse the budgetary and program resources of state and local governments.* As discussions continue on the need for health care reform, it is important that newcomers' health care needs not be overlooked.

Newcomers are a significant and growing part of the diversity and richness of American society. During the 1980s an estimated 9.5 million newcomers entered the United States, the highest decade total in our nation's history, and these numbers promise to continue to increase in the 1990s. Newcomers are making valuable economic and social contributions to virtually every part of our nation's livelihood, yet they raise important questions for the nation's health care policy because of their specialized needs and differing eligibility for federal services.

Newcomers face a number of different barriers to adequate, comprehensive health care. Institutional barriers, such as legal status and program eligibility requirements, prevent some categories of newcomers from participating in government-sponsored health care programs. Foreign languages and cultures contribute to miscommunication between service providers and newcomer patients. Economic barriers prevent many newcomers from purchasing health care on their own. When these barriers prevent newcomers from obtaining adequate health care, their efforts to become self-sufficient are severely impaired.

Federal programs designed to meet newcomers' health care needs are inadequate and fragmented, and over the last decade, the federal government has been shifting newcomer health care responsibilities to state and local governments. In response, state and local governments are beginning to design policies and programs to meet the health care needs of this diverse population. However, because the resources of state and local government are limited, these models are rare and are difficult to replicate.

Although there are other health care issues that concern newcomer populations, this paper concentrates on four main policy areas: access to regular and comprehensive health care; public health; mental health; and the effect of linguistic and cultural barriers on newcomers' use of health care. Each section discusses the needs and problems newcomers have within these specific areas, the current federal response, and some successful state and local programs.

If newcomers have access to regular and comprehensive health care, they can receive primary care in the offices of primary care physicians, obviating the use of hospital outpatient departments and emergency rooms, which increases costs to state and local governments. Public and preventive health issues raised by newcomers (particularly the high incidence of tuberculosis, hepatitis B, and parasites) have serious implications for both newcomers and natives. Mental health problems are cause for concern, particularly for refugees who have suffered the horrors of persecution or torture. Finally, communication problems, either linguistic or cultural, between health care provider and patient may significantly compromise the quality of health care received and the efficacy of treatment.

Because these issues are interrelated, there is some overlap in the presentation. This overlap serves as

*The term "newcomers" includes all foreign-born, regardless of their immigrant status. Terms such as legal immigrants, refugees, legalized aliens, undocumented aliens and so on, refer to specific categories of newcomers. Definitions of these categories are provided in chapter 1.

a reminder that progress in one area of resettlement policy often contributes to progress in other areas. If newcomers are healthy, their prospects for early employment, proficiency in English, and successful resettlement are increased. Therefore, newcomer health care is a cornerstone of any successful resettlement strategy.

Access to Health Care

Access to regular and comprehensive health care is an important component of effective newcomer resettlement. There are a number of variables, such as immigrant status, income, employment, ethnicity, English language proficiency, and unfamiliarity with the American health care system, that influence a newcomer's capacity to obtain primary health care.

Middle class, legal immigrants with employer-sponsored health insurance obtain health care much like their counterparts in the general population. However, while these immigrants are self-sufficient, many would be classified as medically indigent in the event of major or catastrophic illness.

Low-income, legal immigrants and refugees with families are generally eligible for Medicaid benefits. Additionally, low-income refugees who are not eligible for Medicaid are usually eligible for a special Refugee Medical Assistance (RMA) program for their first eight months in the country. The RMA program provides refugees with the same benefits as the Medicaid program. Immigrants and refugees covered by Medicaid or the RMA program are therefore able to obtain health care relatively easily, for the first eight months of arrival.

Legal immigrants and refugees applying for the Medicaid or RMA programs are subject to the same state-created eligibility criteria as U.S. citizens. In some states, the qualifying income level for Medicaid and RMA is lower than in others, thereby disqualifying some working-poor newcomers in these states from participation in the program. In these instances, newcomers with low-paying jobs may be earning too much to qualify for Medicaid or RMA but not enough to allow them to participate in an employer-sponsored health plan or to pay for health care themselves. Migrant farmworkers, particularly, fall into this category. In 1990, the Department of Labor conducted a nationwide survey of the agricultural worker population and found that only 20 percent had employer-sponsored health insurance.

Undocumented immigrants qualify for very limited government health care benefits and are less likely than insured newcomers to have other health care coverage, to use preventive health services, and to receive prenatal care. Although data on the undocumented population are scarce, a study conducted by the Center for United States-Mexican Studies at the University of California, San Diego, between 1981 and 1983 showed that more than 81 percent of the undocumented interviewees lacked public or private insurance coverage and that coverage increased only slightly for undocumented immigrants after long residence in the United States. A 1992 study completed for INS found that 49 percent of the recently legalized alien population had no health insurance, even though many had their legal status for more than one year.

Undocumented immigrants do not routinely seek government health care and other social service benefits because of program ineligibility, high costs, language problems, unfamiliarity with the U.S. health care system, and fear of discovery by the Immigration and Naturalization Service (INS). Although some state and local governments have explicitly instructed their employees not to give any information regarding their clients to the INS, federal law mandates that social workers verify an applicant's immigration status through INS' automated Systematic Alien Verification for Eligibility (SAVE) system.

The health care patterns of low-income, uninsured newcomers often mirror those of their counterparts in the general population. Both groups

1. delay treatment until the medical problem is in its advanced stages and symptoms become acute;
2. neglect preventive health care; and
3. receive primary health care in an emergency room rather than in a doctor's office.

Because newcomer groups, especially undocumented immigrants, are unlikely to receive comprehensive health care or be covered by comprehensive health insurance, they often turn to hospital outpatient departments and emergency rooms to meet their health care needs. California estimates that undocumented immigrants accessing emergency medical services through the Medi-Cal program cost the state approximately $400 million

in FY 1992. Texas estimates that it incurred $16 million in emergency Medicaid costs for FY 1992 and that public hospitals incurred $56 million in costs from serving undocumented immigrants. Florida estimates that it incurred $5 million in emergency Medicaid costs for serving this population in FY 1993.

The Omnibus Budget Reconciliation Act of 1986 allows for partial federal reimbursement under the Medicaid program to health care providers for emergency medical services provided to all low-income residents regardless of their immigrant status. But although the right to emergency medical care is protected by federal and state law, the inappropriate use of these services causes a great deal of concern for state and local governments as well as for health care providers.

State and local governments and hospitals, particularly public hospitals, have a vested interest in reducing newcomers' use of emergency care because it directly affects state and local budgets and hospitals' levels of uncompensated care. Once a case has been determined an emergency by a physician, hospitals with emergency rooms must offer at least initial treatment. Providing these services is proving costly to states, localities, and hospitals because the partial federal reimbursement for the cost of these emergency services is inadequate to offset the costs. States and localities are then placed in the difficult position of either reimbursing hospitals for the outstanding expense or shifting these costs to the hospitals themselves.

From the hospital's perspective, the overuse of emergency services is an inefficient use of its resources because the cost of these services is higher than outpatient services. According to a 1992 article in the *Journal of Legal Medicine*, a few hospitals respond to this budgetary pressure by using a very narrow definition of the term *emergency* and by refusing to serve poor, undocumented immigrants even if they have legitimate medical emergencies. Even though these practices contravene the law, they may often go unpunished because the undocumented population is unlikely to notify the federal government of this violation. Other hospitals shoulder the expense of these uncompensated costs by charging more for services provided to other patients.

Most newcomer patients require more social service interventions than do patients in the general population. They may require more discharge planning and patient education, especially where they are unfamiliar with the U.S. health care system and have limited English language skills. This places an undue strain on public hospitals, particularly in areas where private trauma centers have been closing and at a time when hospitals are being asked to serve more people with fewer financial resources. As government reimbursements decline, hospitals become less able to continue providing uncompensated care.

Uninsured newcomers sometimes choose to purchase health care from underground health care providers who are not licensed or certified by the appropriate authorities. Underground health systems have surfaced in communities with large newcomer populations. These systems provide health care to those who are unable to use the U.S. health care system (e.g., because of their immigration status) or who are unwilling to do so (e.g., because they prefer to go to doctors with a similar ethnic or cultural background even if they are uncertified). Care provided in these clinics is often expensive and may be second-rate or even dangerous.

Federal Programs

Newcomer eligibility for health care. Newcomers are eligible for widely divergent health care benefits, depending on their immigration status. Low-income refugees and legal immigrants are assisted through the Medicaid program. Low-income refugees who do not qualify for these programs may use the Refugee Medical Assistance program during their first eight months in the United States. Undocumented immigrants may receive only emergency services under the Medicaid program.

Under the Immigration Reform and Control Act of 1986, legalized immigrants were barred from certain federal public assistance programs for the first five years of their legal residency. During this five-year period, legalized immigrants were eligible for state and local health programs which in turn could be reimbursed for these medical expenses through the State Legalization Impact Assistance Grant (SLIAG). In May 1993, the ban on federal services ended, allowing the newly legalized to access federal mainstream health care programs.

Public hospitals. Public hospitals are the principal providers of inpatient care for immigrants and refugees. They receive a "disproportionate share

hospital" (DSH) subsidy from the federal Medicaid and Medicare programs to help subsidize care for persons who cannot pay for health care for themselves. Each year the federal government appropriates nearly $2 billion to be divided among approximately 1,600 hospitals that provide a substantial amount of indigent care.

Community health centers. The Health Resources and Services Administration of the Department of Health and Human Services (DHHS) provides funding for community health centers (CHCs) through project grants. Because of their close ties with the community, CHCs can be sensitive to emerging community needs and provide patient care to special populations. Project objectives include improved availability, accessibility, and organization of health care for underserved populations. Funding recipients may include public or nonprofit agencies, institutions, or organizations and a limited number of state and local governments. Recipients must be prepared to assume some project costs.

Migrant health centers. The federal migrant health program funds more than 100 migrant health centers nationally, providing services to approximately 450,000 migrant farmworkers. These health centers provide a range of services that can include preventive health care, dental care, pharmaceuticals, bilingual outreach, and emergency outpatient services. Migrant health center staff often include bilingual and bicultural health care professionals. These facilities are often able to provide the social and support services that hospitals usually cannot provide.

Funding for migrant health centers is available from three different funding streams in the Department of Health and Human Services. The Health Resources and Services Administration provides funding to public or nonprofit organizations, with priority given to community-based organizations representative of the populations being served. The Women, Infant, and Child (WIC) program is a second major source of funding for these centers. Third, the Medicaid program also assists in financing these centers, but providers receive reimbursement for only 50 percent of costs for their services. Unfortunately, the federal government has provided only enough funding to serve between 12 percent and 16 percent of the eligible migrant farmworker population, and these centers do not serve farmworkers who are no longer migrating.

State and Local Programs

Many state and local government general assistance (GA) or general relief (GR) programs provide medical benefits in addition to cash assistance to their eligible low-income residents. These GA medical programs, also called indigent care programs, offer varying levels of care and serve a range of populations. Indigent care programs in some states provide comprehensive medical benefits to all residents regardless of their immigrant status, while other programs provide only emergency benefits to the undocumented or do not serve them at all. All state and local welfare programs must serve eligible legal immigrants and refugees.

PUBLIC HEALTH

Newcomers raise a number of key issues for public health officials. Certain newcomer populations enter the United States with health problems resulting from environmental conditions and inadequate medical care in their countries of origin. Refugees and others fleeing persecution and torture develop health problems en route to the United States or while living in overcrowded resettlement camps with inadequate sanitation facilities. State and local officials have reported that the most significant public health issues confronting immigrants and refugees are tuberculosis, hepatitis B, and intestinal parasitic infection:

- In 1990, the foreign-born population accounted for 25 percent of all tuberculosis cases in the United States. Officials in Texas, California, and Illinois report that the incidence of tuberculosis among immigrants and refugees is increasing, particularly in urban environments and among the farmworker population.

- A 1991 study estimates that between 14 percent and 20 percent of Indo-Chinese refugees in the United States, or 180,000 people, carry the hepatitis B virus. Between 10 percent and 12 percent of the general Southeast Asian refugee population are estimated to be chronic carriers of the virus.

- A 1992 report commissioned by the American Association of Retired Persons states that newcomer populations, and especially refugees and farmworkers, have a high incidence of parasitic infection. According to the Public Health Service, farmworker groups are nearly

50 times more likely to have parasitic infection than the general population.

These health problems are compounded by cultural and linguistic barriers (see the Language and Culture section). Some immigrants and refugees may not be able to adequately communicate their health problems to health professionals or may not be familiar with western medication, germ theory, and general treatment practices. Therefore, newcomers need access to trained interpreters who have a good technical knowledge of medical issues as well as an understanding of the patient's cultural background. Innovative programs at the state and local level are employing bilingual and bicultural health care professionals to provide these services to newcomers.

Disease prevention and health promotion are two critical elements in protecting the public health and containing health care costs. Disease prevention and treatment occur at three different levels. The first level emphasizes preventing disease before it occurs, the second level, early detection and treatment of a contracted disease, and the third, rehabilitation.

Health promotion includes health education and public outreach and, therefore, focuses on such issues as nutrition, physical fitness, reproductive health, and identification of available health care services and resources. Some newcomers need health education regarding emergencies and acute care, including how to call for emergency services and administer basic cardiopulmonary resuscitation. At this time, most refugees receive an initial orientation to the U.S. health care system from their resettlement agencies, but other newcomers receive no such orientation. Some health care service providers also make use of bilingual educational materials to reach out to newcomers and teach them how and where to obtain access to health care. For example, Oregon's refugee program has developed newcomer orientation video tapes with accompanying written materials. However, there is a general need for improved dissemination of these and other materials in Oregon and in other states.

Currently, newcomer health care policy focuses primarily on the second and third levels of disease detection and treatment with emphasis on health screening, health assessment, health education, and required treatment and follow-up. However, the mobility of some newcomer populations has contributed to poor compliance with treatment plans, especially for diseases that require longer term treatment. For example, effective treatment of tuberculosis requires at least six months of regular medication. If the patient discontinues treatment too early, the disease remains uncured and may become drug-resistant. The mobility of newcomer groups also limits the effectiveness of immunization services for the hepatitis B virus and the treatment of other diseases.

Federal Programs

Coordinated assessment and treatment are not uniformly provided by the federal government to America's newcomers. The federal government provides legal immigrants and refugees with a cursory overseas health screening and state governments with limited reimbursement for domestic refugee health assessment and treatment. The overseas health screening ensures that legal immigrants and refugees (1) are free from communicable diseases of public health significance, (2) do not have a mental illness linked to violent behavior, and (3) do not have a drug addiction. Although no one is allowed to immigrate to the United States without passing this medical exam, it is usually possible to obtain waivers that allow immigrants and refugees with treatable conditions to enter the country provided they receive treatment within a prescribed time period. When these exceptions are made, the Public Health Service notifies the appropriate state and local health departments of the arrival of these newcomers in their communities.

Once newcomers enter the United States, certain groups are served by a patchwork of federal public health programs that do not meet all the public health needs of newcomers. Most of these programs are administered by the Department of Health and Human Services (DHHS). For example, the Public Health Service's Centers for Disease Control and Prevention (CDC) oversees specific programs such as tuberculosis control and hepatitis B prevention. The Office of Refugee Resettlement (ORR) provides funds to CDC to identify health problems that might impair refugees' self-sufficiency and to refer these refugees for treatment. The Migrant Health Program provides some preventive services, including immunization and health promotion to a small percentage of the nation's migrant workers. The federal government also provides states with a preventive health block grant that can be used for a variety of public health services.

However, these federal programs fail to meet most of the public health needs of the newcomer population. Mainstream public health programs do not adequately target new arrivals, even though the incidence of diseases such as tuberculosis is higher among newcomers. Federal funds for public health services are often allocated on the basis of newcomers' legal status, not on their health needs. Also, the myriad federal public health programs serving newcomers are underfunded and lack cohesion, consistency, and focus. These problems contribute to an ineffective U.S. strategy for public health treatment because only some newcomers receive needed preventive services.

State and Local Programs

To fill some of the gaps in federal policy, some state and local governments are creating their own public health policies and programs to meet newcomers' preventive health needs. Despite their limited resources, states and localities are realizing that they must go beyond the limited public health support that the federal government offers. For example, Illinois pays for health screenings for Vietnamese immigrants and parolees in the Orderly Departure Program (ODP) who have the same health problems as refugees but are ineligible for federally funded health screening. However, model state and local programs are rare and hard to replicate with existing resources.

Some states and localities are conducting public health outreach campaigns for new arrivals by creating and circulating bilingual educational materials on important public health topics. In Oregon, the state's refugee resettlement office received a grant from the federal Office of Refugee Resettlement to develop multilingual video materials on resettlement topics. Nineteen different tapes in 15 different languages provide an orientation to American society. One 17-minute tape entitled "Using Health Care Services" provides an overview of the American medical system. In Rhode Island, Women and Infants Hospital received a grant from a private foundation to create a series of multilingual videotapes on specific public health issues such as sexually transmitted diseases, tuberculosis, and hepatitis B. Currently, nine tapes are available in seven languages. Both the Oregon and the Rhode Island tapes are available at minimal cost. Information on multilingual videotapes used in other states is available from DHHS' Office of Refugee Resettlement.

State and local government service providers are also learning that building a relationship of trust with their clientele is of utmost importance in their attempts to better steward the public health. In California, Los Angeles County's Edward R. Roybal Comprehensive Health Center, or the "Clinica de Colores" as it is known locally, provides a wide array of bilingual and bicultural public health services to the Hispanic population of East Los Angeles. The center concentrates its public health services in four areas: a chest clinic (for tuberculosis), a sexually transmitted disease clinic, immunization for children and adults, and case management.

Over the last 20 years, the center has worked to include Hispanic community organizations in its outreach and service delivery. Priority hiring is given to Hispanic or other Spanish-speaking administrators, doctors, nurses, clerks, and other staff. Community representatives are regularly invited to discuss appropriate treatment methods and strategies with staff and administrators. The center also insists on maintaining strict confidentiality for its clients.

The fruits of this cooperative effort are the good reputation and word-of-mouth outreach that bring many residents with limited English proficiency to the center's doors. The center reports that even if newcomers move 50 to 60 miles away, they still return to the center for health care. This connection to the community has enabled "Clinica de Colores" to successfully integrate public health services with the culture of its clients.

Refugee Mental Health

Newcomers, especially refugees, suffer adjustment and acculturation stresses associated with adaptation to a new society. The situation is exacerbated if neither family nor society can provide the social or economic support that is needed to smooth the transition and if refugee populations cannot communicate effectively in English. Psychiatric epidemiological studies of the Hmong population in Minnesota have confirmed that refugees within that population who had developed some competence in both oral and written English were better able to adjust to life in the United States and were less likely to become mental health casualties.

Intergenerational and cultural stress within the family unit resulting from immigration to the

United States also may adversely affect newcomer mental health. In a number of newcomer families, parents have had to rely on their children as language and culture brokers and to help them with acculturation. This dependence results in role reversals that may violate cultural values and traditions. Also, the pressure on children to "Americanize" frequently prompts them to abandon cultural traditions, thereby alienating older family members.

Refugees have unique mental health needs. On fleeing their homeland, most refugees have had to leave their savings and possessions behind. Those who have lived in resettlement camps for a protracted period often have feelings of alienation and loss of identity. Many refugees mourn the loss of family members due to war, famine, or attacks as they fled. Surveys conducted by Fred Bemak of Johns Hopkins University reveal that one-third of the refugee population studied felt withdrawn, depressed, and alienated. Of the Amerasians who were interviewed, one-third of the women had been raped, one-third had experienced hunger, and one-third had seen or endured physical beatings. Often refugees operate on "emergency adrenaline" in the early days of arrival, and might experience "post-traumatic stress syndrome" later on.

Refugee mental health issues are cause for concern because orthodox mental health strategies alone have not been effective in treating refugee mental health problems. And even when culturally sensitive services are available, refugees from some cultures are reluctant to get mental health treatment. For example, a study of Afghan refugees has demonstrated that even when Afghan psychotherapists are available, many Afghans do not want to use these services for fear of gossip, losing face, or having to share sensitive personal information. As with other populations seeking mental health care, treatment is compromised by failure to complete treatment or to return for required follow-up.

Major contributors to refugee mental health problems include the following:

1. Changes in socioeconomic status;
2. Loss of a sense of individuality;
3. Torture, persecution, imprisonment, and traumatic departure from country of origin;
4. Unemployment (and underemployment relative to one's level of education);
5. Unrealistic expectations regarding life in the United States;
6. Shortage of mental health professionals willing or able to work with culturally different populations; and
7. Separation from family and social support systems.

Language and cultural barriers as well as inadequate social service support have limited the ability of mental health service providers to meet refugee needs. A fragmented federal mental health policy has exacerbated these problems by not providing support for needed preventive programs or uniformity in service delivery.

Federal Programs

Although Congress has continued to provide funding for refugee resettlement, allocations have been designed principally to promote early employment at the expense of other resettlement needs. Those comprehensive needs far exceed the limited federal funding made available. Significant investment has therefore not been made in long-term infrastructure such as increasing the number of clinics, professionals, and language programs that would help to prevent protracted mental health problems.

The federal programs that provide funding for newcomer mental health include Medicaid, Medicare, the Mental Health Block Grant, Refugee Targeted Assistance, and the Voluntary Agency Matching Grant. Though these funds are not dedicated to mental health, some states and voluntary resettlement agencies have been able to use small portions of these funds for mental health initiatives.

Mental health funding, resource personnel, and treatment centers have not kept pace with the increased refugee demand for mental health services. As early as the mid-1970s, it was observed that refugees suffer a greater number of both minor and major mental health problems even when the new culture is similar to their own. In addition, mainstream mental health resources are often too limited to include refugees. In the mid-1980s, the Office of Refugee Resettlement funded the National Institute of Mental Health to carry out a three-year limited initiative to stimulate refugee programs in several state mental health departments. However, with the elimination of federal funds, those

departments have been unable to put these plans into action.

State and Local Programs

Some state and local governments are trying to pull together the pieces of a coherent and comprehensive refugee mental health policy to meet the increased demand. In their efforts, states and localities are trying to implement responsive, community-based programs that provide professional staff with cross-cultural training and incorporate the cross-cultural approach in their treatment plans. These programs also would aim to allocate resources for and bring into treatment those populations most in need, and they would have the means for early detection and prevention of mental illness.

In the early 1980s, Santa Clara County, Calif., noted a significant increase in its Southeast Asian refugee population. This prompted the county's mental health bureau to use its own funds to conduct a needs assessment survey of the new Vietnamese, Cambodian, and Chinese communities in their own languages. Their findings showed that the Vietnamese and Chinese refugees had twice the mental health needs of the general population, and the Cambodian refugees had eight times the need.

The survey also found that fourth and fifth generation Asian-Americans had different mental health needs and received their care in different settings than did newly arrived Southeast Asian refugees. The acculturated group had lower levels of needs that could be met within general treatment programs while more recent refugees were seen in specialized mental health programs. Further, children were found to need additional mental health resources and services. They are currently underserved, and the number of children in need of services is increasing.

In response to these findings, the Santa Clara Mental Health Bureau reallocated its program resources to target the needs of these populations. The bureau created a mental health center dedicated to serving Southeast Asian refugees and expanded the resources of two other county service providers. Additionally, the county encourages Southeast Asians to obtain social work training at nearby San Jose State University and then actively recruits them as county positions become available.

The mental health bureau, like most other mental health agencies, gets funding from a variety of different sources. Slightly less than 50 percent comes from Medicaid and Medicare, approximately 30 percent comes from special state tax revenue, another 20 percent comes from county funds, and the remainder comes from sources like the federal Mental Health Block Grant. Between FY 1991 and FY 1993 the mental health bureau's budget increased from $76 million to $92 million. However, despite the county's continued support for the program, severe budget problems have forced it to reduce its FY 1994 contribution by $14 million.

In 1980, the St. Paul International Clinic in Minnesota was opened to provide adult medical services for refugees of different nationalities. During the first three years, physicians began to suspect that some refugees had mental health problems that were manifesting themselves as physical problems. Starting in 1984, the clinic began to employ psychiatrists and later a psychologist to provide both medication and psychotherapy to mentally ill refugees. The clinic has also been able to hire a Hmong nurse to assist with the large number of Hmong the clinic serves. The clinic also has nine interpreters on staff who interpret in nine different languages. Psychiatrists and psychologists each work with interpreters.

Other providers, such as Miami's New Horizon Community Mental Health Clinic, are incorporating the cross-cultural approach to treatment plans in culturally diverse communities. This approach recognizes the complementary roles of modern and traditional or alternative treatment, especially in mental health programs.

Language and Culture

Linguistic and cultural differences coupled with unfamiliarity with the U.S. health care system result in decreased access to health care for non-English-speaking newcomers. The ability to maintain effective communication between health care provider and patient is therefore critical to the quality of patient care. Good communication between health professionals and newcomer patients is particularly crucial for those medical procedures that require the patient's informed consent. If patients cannot understand the need for

a proposed procedure, they usually will not give their consent.

The Census Bureau estimates that, in 1990, 30.3 percent of the 520,504 Asian language households and 23.4 percent of the 1,596,405 Spanish language households were "linguistically isolated," meaning that there is no one over the age of 14 in the household who speaks English well. But although these newcomers are unable to communicate effectively in English, few hospitals offer translation services and trained interpreters to serve newcomers with limited or no skill in English. The lack of interpreter services within medical settings is cause for concern in light of the changing demographics of the U.S. population. According to a staff member of the House Subcommittee on Health and Environment, "If you're accused of a crime in this country, when you go to court someone will interpret for you. If you're sick and you need a doctor, you're on your own."

In a recent study, the *Chicago Reporter* noted that an estimated 20 percent to 25 percent of Chicago residents need translating assistance at hospitals or health clinics. Although more than 59 languages are spoken in Chicago, 71 of the 84 hospitals and clinics who responded to this survey said that they have not hired interpreters, and only two of the 34 suburban facilities have interpreter services. Of the 70 facilities who use staff employed in other jobs for interpretation purposes, only 11 train them, even though they may have to translate complicated medical terms. Ten hospitals and clinics reported using housekeeping employees to interpret, 27 use clerks as well as other employees, 20 medical facilities ask patients to bring their own interpreters, and one tells them to go elsewhere for service if they cannot provide their own interpreter. Some health providers and families rely on children to translate. This can violate social and cultural norms, put undue pressure on children (see the Mental Health section), and lead to deliberate masking of symptoms and, therefore, improper diagnosis.

The University of Illinois at Chicago recently conducted a survey of 141 Cook County hospitals and clinics. Of the 42 responding, only 10 percent of the hospitals provide intake forms in Spanish, while nearly half the clinics do. The study also confirmed that medical interpreter services are provided haphazardly and that there is a need for policy and programs in this area. Chicago Travelers and Immigrants Aid, which commissioned the study, has since formed a task force that has suggested ways to train and certify health care providers.

One way to overcome language and cultural barriers would be to hire immigrant doctors, nurses, and other health professionals. This solution is problematic because of the stringent standards and certification requirements the U.S. medical community places on foreign-trained personnel. Doctors and nurses are often required to repeat entire education and training programs to obtain U.S. certification, even if immigrant health care professionals can document that they have received a comparable education overseas.

Specific cultural traditions and experiences affect newcomer access to health care in a variety of ways. Newcomers frequently are unaccustomed to western medical practices and may be unfamiliar with basic germ theory. Newcomers may also be more comfortable with alternative remedies and treatments (e.g., herbal medication, spiritual healing) than with western treatment procedures (e.g., injections). Some newcomers are apprehensive of large hospitals and the prospect of describing personal ailments to an unknown doctor or nurse.

Federal Programs

The federal government has no coherent policy or programs that address language and cultural barriers to immigrant health care. Although interpretation and translation services are reimbursable expenses under the Medicaid program and DHHS does have a policy of supporting interpretation services where necessary, state claims for these costs are rarely honored because of insufficient federal appropriations. However, some progress was made beginning in 1985 when the Office for Minority Health (OMH) was created by DHHS. In 1990, the Congress passed the Disadvantaged Minority Health Act, which created the Office of Deputy Assistant Secretary for Minority Health in DHHS. This office is charged with activities related to disease prevention, health promotion, service delivery, and research concerning disadvantaged minorities. OMH also distributes a limited number of grants to help health care providers obtain the assistance of bilingual health professionals and staff.

State and Local Programs

Interpretation and translation. To bridge the communication gap, some health care providers have now hired full-time, part-time, or contract translators. Efficiency indicators at the Roanoke (Va.) City Health District Refugee Clinic point to the value of early interpreter intervention. In the Roanoke program, outreach workers provide translation services during clinic and home visits, enabling staff to complete and assess patient health histories and explain needed follow-up. Bilingual staff contribute to improved patient flow and reduced clinic and personnel costs. The introduction of a family-centered clinic has eliminated the previously fragmented health care delivery system. Families go to one clinic per month, which lessens clinic confusion and saves time. Interpreters are now in the clinics when the refugees are there, leading to better use of clinic time and resources.

Other programs have also hired bilingual employees or contracted with on-call language banks that provide interpreter services. Since 1986, Boston City Hospital has been operating a 24-hour health hotline in 25 languages, which explains how and where residents can obtain health care services in the Boston area. A number of states and local government agencies contract with a telecommunications company for translation assistance over the telephone. Interpreters for 140 languages are on call nationwide. However, this telephone line service is expensive and is not an adequate substitute for the physical presence of interpreters who can read body language and facial expressions.

In Seattle, Wash., a coalition of Seattle/King County, nonprofit, and private service providers sponsor a 12-hour interpreter training program taught by a trained interpreter. The class helps interpreters identify their role in service delivery; addresses interpreter ethics, professional presentation, and proper procedures; conducts translation and language-strengthening exercises; and helps interpreters develop cultural models that help them understand their clients. The cost to sponsoring agencies for this training is a nominal $65 per student. The class is offered four to five times per year, and there is enough demand for the class to meet even more frequently.

Seattle's Pacific Medical Center is using a grant from the Kellogg Foundation to create an interpreter forum. The forum provides more specific and technical training about different medical terminology and procedures for interpreters. As interpreters finish the 12-hour course, many of them attend the monthly meetings of this forum for continuing education.

Cultural differences. Even though progress is being made in translation services, health care professionals say that the real need is for biculturally appropriate services and bicultural service providers.

In an attempt to address this problem, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (VDMH) has established multiethnic, multicultural advisory councils to define culturally appropriate services, determine which services are needed, and assist in training service providers to meet these needs.

The Massachusetts Department of Public Health (MDPH) and its Office for Refugee and Immigrant Health have created the Committee for Culturally and Linguistically Relevant Health Education. The committee, consisting of interested MDPH staff members, assists program administrators within MDPH in translating, adapting, or developing health education materials for specific newcomer communities that are culturally and linguistically relevant. This committee has helped to institutionalize the certification of culturally appropriate education materials.

The Santa Clara County (Calif.) Mental Health Bureau has established a policy that the ethnic composition of the staff in its various programs should reflect the ethnic population of its clients. Their intervention strategies involve inclusion of minorities in the planning of new services, development of a specific hiring plan, creation of new agencies and services, and adjusting priorities of existing agencies.

The bureau conducted a study in 1989 to determine the effect of ethnic matching of therapist and client on the length of treatment and service utilization patterns. The results indicated that matching the ethnicity of client and therapist had a positive effect on the length of treatment and also reduced the client's use of emergency and inpatient services.

In the development of quality services for ethnically diverse populations, some providers have incorporated into their program philosophy the concept that services must be designed to meet the needs of individuals as members of their respective

ethnic groups and must coincide with the client's world view. Increased emphasis is therefore being placed on the cross-cultural approach to treatment plans in culturally diverse communities.

Professional relicensure. Some highly educated immigrant populations have problems integrating with the U.S. workforce because of their limited proficiency in English. It is difficult for foreign-born professionals, including doctors, nurses, and pharmacists, to obtain even entry-level positions or U.S. accreditation. Medical schools generally do not give full credit for foreign credentials. It is also difficult for foreign-trained health professionals to compete with U.S. trained professionals for a limited number of residency positions. Vocationally appropriate courses in English as a second language and assistance with recertification are suggested for these population groups as a method of accelerating re-entry into their chosen profession. Additionally, the creation of residency programs, perhaps within community health centers, for foreign-trained medical professionals would also help meet these needs for retraining and recertification.

Credentialing of foreign-trained health care professionals may help alleviate the U.S. labor shortage in the health professions as well as meet the need for bilingual and bicultural staff. Early credentialing of foreign health care professionals has three distinct advantages:

1. It helps newcomers become employed more quickly, thereby reducing unemployment and underemployment within these populations.
2. It helps meet the needs of the health care industry for skilled professional personnel.
3. It facilitates the delivery of culturally sensitive health care services to other newcomers.

With initial funding obtained from New York's Health, Education, and Social Services departments, the New York State Refugee and Immigrant Health Professional Transition Initiative was formed in 1991 to help legal immigrants obtain appropriate licenses to practice in the state. The initiative (1) evaluates programs and makes recommendations to replicate, modify, or discontinue programs and (2) develops methods to accelerate professional relicensure at cost-effective rates.

Current programs include preparing foreign-educated health professionals for nursing, laboratory; and physical therapy certification. The program has also been awarded funding to retrain Latino medical graduates as physician assistants and respiratory therapists. These programs are expected to train more than 200 immigrants for health careers in New York City.

The Nurses Tutoring Project, a nonprofit agency in Chicago, has struggled for survival since its founding in 1974. The project provides education and counseling services to all nurses and students regardless of race, gender, age, creed, or national origin. It provides vocational English classes to an average of 250 foreign-born nurses annually.

Conclusion

The fragmentation of the U.S. health care system adversely affects newcomer access to adequate health care. Because the U.S. system is employer-based, many unemployed or underemployed newcomers do not have health insurance. Even when some newcomers have full-time employment, they may not be able to afford employee contributions to employer-sponsored health insurance.

Federal government-sponsored health care is available for some immigrant categories but not for others. This is particularly problematic when members of the same family have identical medical conditions but only those with particular, authorized immigrant status have access to care. Others must find a way to pay for their own care or delay treatment until emergency care is required.

Working-poor newcomers sometimes are ineligible for Medicaid, Refugee Medical Assistance (RMA), or indigent care because they do not meet the program requirements. For example, Georgia reports that some refugees find work so quickly that they lose their eligibility for the RMA program before the allowed eight months has elapsed. Other working-poor newcomers are ineligible for programs because they do not have legal immigrant status. Often they are unable to afford the cost of private insurance as well. Without access to government- or employer-sponsored health care, working-poor and undocumented newcomers do not receive the preventive health care they need and, therefore, seek treatment in emergency rooms where they must be served. By delaying treatment in this manner, newcomers may develop more

serious medical conditions that are in turn more costly to treat.

Newcomers who can gain access to health care in the United States are often poorly served because health care providers do not usually have the multilingual and multicultural resources needed to serve them. Few hospitals and clinics have adequately trained interpreters or bilingual and bicultural professionals on their staffs. These resources are needed to bridge the communication gap between service providers and their racially and ethnically diverse patients. Inadequate interpreting services may result in miscommunication, misdiagnosis, and improper treatment. As a result of these economic, institutional, linguistic, and cultural barriers to health care, newcomers are routinely underserved by the U.S. health care system and sometimes they are not served at all.

States, localities, and others are trying to compensate for the deficiencies in the current system. Some state and local newcomer health care programs have supplemented programs sponsored by employers or the federal government with state or local funds or even with new programs. Others have devised effective policies to better meet newcomers' needs for multilingual and multicultural health care.

These programs and policies have proved successful and can serve as good models for broader use. However, state and local governments do not have the resources to develop more comprehensive approaches, and so they are ultimately reliant on the federal government to meet these broader needs.

As the United States considers reform of the health care system, it is crucial that any new national system take into consideration how health care coverage will be provided to newcomers. Without improved health care access for newcomers, federal, state, and local governments will be unable to provide efficient, inexpensive, and appropriate health care services to these populations.

Furthermore, if some newcomer populations are left uncovered, states and localities will be required to provide at least emergency services to these groups because of court orders, despite the fact that states and localities have no authority to limit immigration into their communities. This is an expense that states and localities cannot afford, particularly in light of current fiscal constraints on state and local human resource budgets.

Newcomer health care needs affect not only newcomers themselves, but also the communities in which they live. When newcomers are healthy, they can integrate into their new communities, gain employment, and become self-sufficient much sooner. As federal, state, and local governments and other partners cooperate to improve the nation's immigrant policy, better health care access for newcomers must be a cornerstone of a successful resettlement strategy.

REFERENCES

Baker, Judith. "Cross-cultural Medicine: A Decade Later." *The Western Journal of Medicine* 157, no. 3 (September 1992).

Barudy, Jorge. "A Programme of Mental Health for Political Refugees: Dealing With the Invisible Pain of Political Exile." *Social Science and Medicine* 28, no. 7 (1989): 715-727.

Cassely, Mary E. *Undocumented Aliens and the U.S. Health Care System.* Washington, D.C.: American Association for Retired Persons, July 1992.

Clabots, Renee B., et al. "The Multilingual Videotape Project: Community Involvement in a Unique Health Education Program." *Public Health Reports* 107, no. 1 (January-February 1992): 75-80.

Gage, Larry S., et al. *America's Safety Net Hospitals: The Foundation of Our Nation's Health System.* Washington, D.C.: National Association of Public Hospitals, January 1991.

Greenberg, Liza, and Monica Perz. *ASTHO Bilingual Health Initiative Report and Recommendations: State Health Agency Strategies to Develop Linguistically Relevant Public Health Systems.* Washington, D.C.: Association of State and Territorial Health Officials, July 1992.

"Health Care Access for Non-English Speakers: 29 City/County Local Health Department Programs." *Local Health Officers News* 32, no. 7 (November 1992).

Hill, Linda, et al. "Prevention of Hepatitis B Transmission in Indo-Chinese Refugees with Active and Passive Immunization." *American Journal of Preventive Medicine* 7, no. 1 (1991): 29-32.

Hubbell, Allan F., et al. "Access to Medical Care for Documented and Undocumented Latinos in a Southern California County." *The Western Journal of Medicine* 154 (April 1991): 414-416.

Loue, Sana. "Access to Health Care and the Undocumented Alien." *The Journal of Legal Medicine* 13 (1992): 271-332.

Meinhardt, Kenneth, et al. "A Method for Estimating Underutilization of Mental Health Services by Ethnic Groups." *Hospital and Community Psychiatry* 38, no. 11 (November 1987): 1186-1190.

Monteiro, Lois A. "Immigrants Without Care." *Society* (September/October 1977): 38-42.

National Health Reform and Access for the Underserved. A Policy Symposium on the Health Care Safety Net, sponsored by the Kaiser Family Foundation and the Robert Wood Johnson Foundation, February 22, 1993. Washington, D.C.: Service Employees International Union, AFL-CIO, Canadian Labor Congress, 1993.

Richmond, Ruth. "Failure to Communicate." *Chicago Reporter* 22, no. 3 (March 1993).

Rumbat, R.; L. R. Chavez; R. Moser, et al. "The Politics of Migrant Care: A Comparative Study of Mexican Immigrants. In *Research in the Sociology of Health Care*, edited by Dorothy Wertz, vol. 7. Greenwich, Conn.: JAI Press, 1988.

State and Local Coalition on Immigration, *America's Newcomers: A State and Local Policymakers' Guide to Immigration and Immigrant Policy*, by Jonathan C. Dunlap. Denver, Colo.: National Conference of State Legislatures, 1993.

U.S. Department of Justice, Immigration and Naturalization Service. *Immigration Reform and Control Act: Report on the Legalized Alien Population.* March 1992.

U.S. General Accounting Office. *Hired Farmworkers: Health and Well-Being at Risk.* GAO/HRD-92-46. February 1992.

Westermeyer, Joseph. "Prevention of Mental Disorder Among Hmong Refugees in the U.S.: Lessons From the Period 1976-1986." *Social Science and Medicine* 25, no. 8 (1987): 941-947.

BEST COPY AVAILABLE

3. EMPLOYMENT AND TRAINING PROGRAMS FOR IMMIGRANTS AND REFUGEES

Ann Morse
National Conference of State Legislatures

By the year 2000, nearly one-fourth of new workers will be immigrants

—U.S. Department of Labor

Chapter 3 was originally published as America's Newcomers: Employment and Training Programs for Immigrants and Refugees *by the National Conference of State Legislatures, October 1993.*

INTRODUCTION

The topic of immigrants and jobs usually leads to controversy, with opponents of immigration stating that immigrants take jobs and displace American workers and depress their wages, while proponents believe immigrants create jobs and markets. A number of researchers have explored the issue of labor market effects of immigration. In a recent review of fiscal studies on immigration, Rothman and Espenshade found that, "Sometimes the consequences for natives' earnings and employment are negative and sometimes they are positive, but in almost all instances the effects are weak or insignificant."[1]

The focus of this report is not, however, to debate the impacts of immigrants on the labor market, but to discuss the reality of a multilingual, multiethnic workforce and the services available in the current employment and training system. The issue for state and local policymakers is how to assist these legal residents, admitted by federal law, to become productive members of their adopted communities and to contribute to the nation's goal of a competitive workforce.

Trends in federal programs and in the demographics of immigrants are leading to an increasing gap in services at a time of increasing need. Federal job training programs (JTPA and JOBS) serve a small percentage of the eligible population, and the few targeted programs for refugees and immigrants have endured drastic funding reductions and delays. At the same time, language and literacy barriers reduce access to these programs for refugees and immigrants.

A growing proportion of the U.S. immigrant population has limited English skills and a low level of schooling. In a November 1989 census survey, 24 percent of immigrants aged 16 and older reported that they spoke only English at home; 45 percent spoke another language and spoke English well; and the remaining 32 percent spoke English "not well" or "not at all." Immigrants also tend to fall along educational extremes: although a little more than one-fourth of new immigrants are college graduates, about one-fourth have attended less than nine years of school.

Demographers project continuing high levels of immigration. Approximately one million immigrants enter the United State each year: 480,000 arrivals through family visas, 140,000 arrivals through worker visas, and 55,000 through special "diversity" visas; approximately 120,000 refugees and an estimated 200,000 undocumented immigrants enter and remain in the United States. Most of the 140,000 worker visas are provided to those with "extraordinary ability," professionals with advanced degrees, skilled workers, special immigrants (such as religious workers), and investors.

Immigrants currently make up 8 percent (14.9 million) of the nation's workforce. Of the 14.9 million, 6 million are Hispanic, 3.1 million Asian, 4.8 million white non-Hispanic, 0.9 million black, and 0.1 other. The U.S. Department of Labor projects that immigrants will comprise nearly one-fourth of new workers by the year 2000 (due to demographic trends such as a low U.S. birthrate and the aging of the population).

This chapter outlines the main federal programs that provide employment and training services, and examples of successful programs that serve the foreign-born. The chapter also highlights issues raised by participants of the Immigrant Policy Project's regional meetings convened in 1992-1993.

Federal Programs for Employment and Job Training

The main federal programs that provide employment and training services are the Job Training Partnership Act (JTPA) for disadvantaged adults and youth and the Job Opportunities and Basic Skills (JOBS) program, a welfare-to-work program. However, participation rates in these programs by immigrants is difficult to ascertain: programs track use by ethnicity, not by immigration status per se. Two programs within the U.S. Department of Health and Human Services (HHS) also provide employment, job training and educational services for specific immigrant populations (for refugees and aliens legalized under the Immigration Reform and Control Act [IRCA]).

The Job Training Partnership Act of 1982 (JTPA)

JTPA is the largest system of federal job training programs, funded at approximately $4 billion through the U.S. Department of Labor (DOL). The programs serve economically disadvantaged adults and youth, older workers, dislocated workers, migrant and seasonal farmworkers, Native Americans, and others who face significant employment barriers. Participation is open to U.S. citizens, lawful permanent residents, refugees, asylees and parolees, those legalized under IRCA, and individuals authorized by the U.S. attorney general to work in the United States.

The JTPA program was amended in 1992 in an attempt to better serve those with the greatest need, by designating target groups with barriers to employment. At least 65 percent of those served must fall in one or more of the listed target groups (including those deficient in basic skills, e.g., English, reading, or computing skills at or below the 8th grade level; school dropouts; welfare recipients, etc.). Local areas may add one additional target group.

Services include (1) direct training and (2) training related and supportive services. Direct training includes basic skills, on-the-job training (OJT), assessment and counseling, education-to-work transition activities, bilingual training, and customized training. Training-related and support services include job search assistance, outreach, and services to enable participation in the program, such as child care. The amendment added as an allowable activity bilingual training and outreach for individuals with limited proficiency in English. Local areas must provide an assessment of skill levels and service needs of each participant, develop individual service strategies, review individual progress, and refer to appropriate training and services. Funds are authorized at a 10 percent increase each year to expand services. Technical assistance funds are available to support replication of successful programs.

Linkages. Local job training programs are required to establish appropriate linkages with other federally authorized programs, such as the Carl Perkins Vocational and Applied Technology Education Act, JOBS, food stamps, the National Literacy Act, and Head Start, as well as appropriate state and local educational agencies, community organizations, and other training, employment, and social service programs. The 1992 amendments also authorize states to establish a single Human Resource Investment Council for JTPA, Carl Perkins, Adult Education, Wagner-Peyser, JOBS and food stamp employment and training programs.

Migrant workers. According to the National Commission for Employment Policy, the federal government spends $600 million annually on 13 programs that provide education, training, and health care for migrant and seasonal farmworkers, most of whom are foreign-born. (Four programs account for 88 percent of the funds: migrant education, migrant health, the JTPA farmworker program, and Migrant Head Start.) The commission notes a lack of coordination in eligibility criteria and grouping of services for the migrant population. A 1992 commission report recommends that government agencies improve coordination of their policies and programs to deliver a comprehensive set of services, and to develop a common framework for streamlining eligibility requirements.

Job Corps. Job Corps is a residential educational and vocational training program for at-risk youth. While it does not keep data specifically on immigrant status, it does measure program use through five major ethnic groups. In San Francisco, for example, approximately 33 percent of the students are Hispanic, 25 percent black, 24 percent white, 10 percent Asian-Pacific Islander, and 5-6 percent American Indian. Job Corps has developed a national curriculum with materials in 23 languages; English language classes are provided at each center. The average length of the

JTPA in Brief

"It is the purpose of this Act to establish programs to prepare youth and adults facing serious barriers to employment for participation in the labor force by providing job training and other services that will result in increased employment and earnings, increased educational and occupational skills, and decreased welfare dependency, thereby improving the quality of the workforce and enhancing the productivity and competitiveness of the Nation." Job Training Reform Amendments of 1992, P.L. 102-367.

JTPA includes programs for disadvantaged adults and youth (Title II, $1.8 billion, plus a summer program for youth, funded at approximately $700 million); dislocated workers (Title III, $577 million); federally administered programs such as for migrant and seasonal farmworkers ($77 million), Job Corps ($955 million), veterans, and the National Commission for Employment Policy (all in Title IV).

Disadvantaged adults and youth (Title II). In FY 1991, an estimated $1.8 billion was spent for training of 721,000 disadvantaged adults and youth, serving approximately 5-10 percent of the eligible population. The summer employment and training program for youth provides remedial education, classroom and on-the-job training, and work experience at the minimum wage. Approximately $700 million has been available annually, serving about 600,000 youth.

Dislocated workers (Title III). JTPA includes a $577 million program for dislocated workers, designed to assist those who have recently lost their jobs due to mass layoffs or plant closings. Others eligible under this program include long-term unemployed people with limited local opportunities for jobs in their fields; farmers, ranchers or self-employed individuals who become jobless due to general economic conditions or natural disasters. Services include retraining (classroom and on-the-job training, remedial education including literacy or ESL), and readjustment training (assessment, career counseling, job placement, job development and supportive services).

Administration of Titles II and III. These programs are administered largely at the local level. General policy guidance is provided by the State Job Training Coordinating Council, appointed by the governor, and composed of representatives of business, state and local government, organized labor, community based organizations, and the general public. The governor establishes "Service Delivery Areas" (SDAs) to receive job training funds. Within each SDA, local officials and Private Industry Councils (PICs) are partners in developing and implementing the job training program. PICs consist of representatives from the private sector, educational agencies, organized labor, community based organizations, and public assistance agencies. 77 percent of the Title II-A (adult training) funds to states are allocated to the SDA/PICs (the core program). The remaining 23 percent is earmarked: 5 percent for state administration, 8 percent for basic education and coordination, 5 percent for older workers, and 5 percent for service delivery areas that exceed their performance standards, or for technical assistance activities. One hundred percent of Title II-B (summer youth), 82 percent of Title II-C (youth training), and 50 percent of Title III are allocated to SDAs.

Migrant workers (Title IV). Section 402 of JTPA provides the principal federal training program for migrant farmworkers. The program is funded at $77 million for 1992and serves approximately 55,000 farmworkers and their dependents, or 2 percent of the eligible population. Services include adult and basic education, ESL, on-the-job training, counseling, and support services (including day care, health care, legal aid, transportation). Support services are limited to 15 percent of funds.

Job Corps (Title IV) is a federally administered residential education and vocational training program for at-risk youth, aged 16-24. Originally established as part of the Economic Opportunity Act of 1964, the Job Corps is a partnership of federal government, organized labor and private industry, volunteer and national nonprofit advocacy organizations. Funded at $955 million, Job Corps provides comprehensive services: basic education, vocational training, health care, counseling, support services, and cultural awareness classes. The program serves approximately 68,000 youth each year who are poor, school dropouts and either unemployed or not in the labor force (reaching approximately 2 percent of those in need).

program for an individual is 10 months. It is an open-entry, open-exit program; enrollees are self-paced for advancement. In San Francisco, the current waiting list to enter the program is over 1,000.

Evaluations of JTPA. In 1991, the General Accounting Office (GAO) reported that services differ by demographic group: white participants were more likely than minorities to receive classroom training and on-the-job training; minorities were more likely to receive only job search assistance. Participants receiving classroom training have the highest average placement wage upon completing training; job search assistance alone resulted in the lowest average placement wage.[2]

According to the GAO, several factors contribute to disparities in services provided to minorities: financial incentives in performance-based contracts that value the number of participants trained or placed in jobs (not the benefit to the participant); the lack of an independent and comprehensive assessment process; the lack of support services such as child care and transportation; and the discriminatory actions of some employers.

The GAO report stated, "in the case of minorities and women, service providers tend to steer them toward low-skilled, low-wage jobs because that is the easiest way to achieve performance benchmarks and receive payments under their performance-based contracts." Also, many providers "offer traditional, stereotypical training because it is inexpensive to set up, jobs are plentiful, and most participants can easily complete the training."

A 1992 evaluation of JTPA (Title II-A) indicated that JTPA had generally positive effects on earnings and employment of adults, but little or no effect on female youths, and substantial negative effects on male youths. JTPA did not appear to benefit Hispanics; their post-training earnings were lower regardless of age or gender.[3]

GAO reported that support services for JTPA need to be improved. The June 1992 report noted that participants who received child care support were more successful in completing training and finding jobs. However, only 9 percent of Service Delivery Area funds were spent on support services.

Performance standards. JTPA has been criticized in the past for "creaming" the most employable people and screening out those who are harder to serve in order to meet performance standards that rewarded high job placements. For example, minimum entry requirements for certain programs often limited access for those with limited English skills, excluding those with less than a sixth grade education. The system rewarded short programs and quick job placement rather than improved skills for the student.

The 1992 JTPA amendments directed DOL, in consultation with the U.S. Department of Education and HHS, to prescribe performance standards based on factors including placement and job retention for six months in unsubsidized employment, increased earnings, reduction in welfare dependency, and acquisition of skills. Governors may prescribe variations in the standards based upon economic, geographic and demographic factors in the state. States must make efforts to increase services and positive outcomes for hard-to-serve individuals.

The JTPA program in Yuma, Ariz., implemented a pilot program months before the 1992 amendments in order to better provide for the "hard to serve." Clients who are monolingual Spanish, limited English proficient, or functioning below a fifth grade level may enter the Educational Opportunities Center to reach language, literacy and basic education levels that will enable them to undertake vocational training. Despite this and other efforts, local administrators estimate only 5 percent of the demand in Yuma County is met.

A JTPA-funded program that has been praised for its success with the "hard to serve" is the Center for Employment Training (CET), a community-based organization in San Jose, Calif. CET combines practical occupational training for all participants in an open-entry, open-exit setting. No minimum educational level is required for enrollment. English as a second language and basic remediation are provided as needed within the vocational training. A Mathematica Policy Research, Inc., evaluation of CET found that participants with the greatest barriers to employment derived the greatest benefit from participation.

It should be noted that evaluation of JTPA programs is difficult because of the latitude localities have to design programs to fit the unique needs of the community. Federal funds are distributed to states, who must pass through most of the funds to localities, called Service Delivery Areas (SDAs).

Each SDA decides where funds are allocated, the programs offered, and therefore what kinds of clients will be served. Programs, services, and administrative structures thus vary from area to area.

Job Opportunities and Basic Skills Training Program (JOBS)

Created by the Family Support Act of 1988, the JOBS program is a "welfare-to-work" program for recipients of Aid to Families with Dependent Children. The program provides employment, education, and job training to assist poor families with children become self-sufficient. Eligibility is open to citizens, legal permanent residents, those "permanently residing in the United States under color of law" (PRUCOL), such as conditional entrants, asylees, refugees, or parolees.

Eligibility for certain aliens has been decided by the courts because AFDC regulations do not define PRUCOL beyond categories specified by Congress. *Holley v. Lavine* extended eligibility for those residing under "official permission or discretion." *Sudomir v. McMahon* refused eligibility for a pending asylum applicant, as the applicant had only the possibility of residence, not official authorization, express or implied. Legalized people under IRCA were barred from accessing AFDC (and thus JOBS) for five years after they were granted temporary resident status. The five-year bar phased out in May 1993.

Implementation Issues. In FY 1992, states spent approximately two-thirds of the $1 billion appropriation. States were unable to draw down the full appropriation because tight state budgets precluded raising the required matching funds. Only 11 states claimed their full allocation of federal JOBS funds. States spent $437 million on JOBS-related child care. GAO reported in September 1991 that states have shortages of services such as basic and remedial education (especially in rural areas) and that two-thirds of the states have shortages in child care and transportation.

Regulations. The "100-hour rule" mandates that an AFDC primary wage earner, such as a JOBS participant, lose benefits if he or she exceeds 100 hours of work per month.

Demonstrations authorized by HHS are under way in California, Wisconsin, and Utah to test a definition of unemployment easier to meet than the 100-hour rule. (A California refugee demonstration project found that waiving the 100-hour rule increased the level of job entries, but it may not be a major factor in reducing welfare dependency.) The "20-hour rule" requires participants to engage in 20 hours of program activity a week to be counted toward a state's required participation rate, but most educational programs require only 12-18 classroom hours.

Evaluations. Since JOBS was implemented so recently, few studies have yet been conducted on the effectiveness of the program, and no research is available that measures specific immigrant participation in the program. The following evaluations are provided to give an indication of the potential success of JOBS and the extent to which minorities access and benefit from employment and training programs.

Preliminary results of a study of six counties in the California GAIN program (a precursor of the national JOBS program), indicates that the program is successful in achieving higher earnings for participants and lowering state expenditures on welfare. The Manpower Demonstration Research Corporation (MDRC) reported that the average single parent participant earned 21 percent more than a welfare recipient in a control group; welfare savings averaged 6 percent.[4]

MDRC notes that a key feature of the program is the use of educational and basic skills levels to place participants in two different tracks: those without a high school diploma, fail to achieve a certain math and literacy level, or are not proficient in English, are placed in basic education classes. Those who are judged not to need basic education must usually participate in job search first. Participants already in approved education and training programs when they enter GAIN may continue in those programs.

In a review of 1980s welfare-to-work programs, MDRC found that almost all programs studied led to earnings and/or employment gains; however, employment and earnings impacts did not occur when resources per eligible individual were too low to provide employment-directed assistance, or when programs were operated in a rural, very weak labor market.[5] MDRC notes that administrators may face trade-offs in meeting JOBS objectives (earnings gains, welfare savings, or reducing long-term dependency). For example, low-cost services may reach greater numbers of people, but achieve less long-term impact.

JOBS in Brief

Funding
JOBS is a capped entitlement. Funds are available to states at a match rate up to the overall JOBS funding cap, authorized at $1 billion for federal FY 1993; $1.1 billion in 1994; $1.3 billion in 1995; and $1 billion thereafter.

Target groups
The JOBS program requires that a minimum percentage of the AFDC population be served. In 1993, 11 percent of the nonexempt AFDC caseload must participate in JOBS in any given month, rising to 15 percent in 1994, and 20 percent in 1995. JOBS also requires that 55 percent of JOBS funds be spent on target groups, such as teen parents and long-term welfare recipients (defined as families on assistance for more than 36 months). (States that do not meet both requirements lose the ability to claim enhanced federal match for JOBS.)

Services
States must offer the following: education, job skills training, job readiness, job development and job placement, and supportive services such as child care. Educational services include literacy, remedial education, ESL, and assistance in obtaining a high school diploma or the equivalent. States are also required to offer two of these four activities: group and individual job search; on-the-job training; work supplementation programs; or community work experience. Child care funds for JOBS participants are available under a separate, open-ended entitlement at the Medicaid match rate. (Transitional child care is also available for 12 months after the parent stops receiving AFDC.) Transportation and other work-related costs are reimbursed at 50 percent and apply to the JOBS cap.

Administration
At the federal level, JOBS is managed by the Administration on Children and Families in the U.S. Department of Health and Human Services. States administer JOBS through the welfare agency. The state office may provide services directly or contract with JTPA administrative entities, state and local education agencies, and other public or private organizations, including community-based organizations.

In Connecticut, the Department of Income Maintenance found several barriers for Puerto Rican families to becoming self-sufficient: JTPA screens out people who are not language proficient; Latino culture encourages women to stay home and care for their children; lack of family support for child care; and lack of family and peer support for self-improvement. Connecticut reorganized the JOBS program and made it more family systems oriented; created contract opportunities with community-based organizations; linked programs with the Department of Labor to blend job placement and family-focused human services; and reorganized the human services program.[6]

A study of the Massachusetts Employment and Training (ET) Choices Program (1987-1990) found that Latinas, despite high participation rates, had poor outcomes for job placement and wages.[7] Job placement for all women was 44 percent; for Latinas it was only 28 percent. (Language was *not* found to be a factor in placement.) The most successful programs were those which aided the development of English language skills combined with skills and job training programs. However, 66 percent of Latinas were in education-only programs. The report suggested that one reason for the poor outcomes was insufficient resources for community-based organizations (CBOs) to develop integrated programs of skills and training combined with language and literacy education. (CBOs are the typical route of entry for Latinas into the program.)

Immigrant and Refugee Programs

The U.S. Department of Health and Human Services (HHS) administers two programs targeted to specific immigrant groups: the SLIAG program for undocumented immigrants legalized under the 1986 Immigration Reform and Control Act and the domestic refugee resettlement program, established by the Refugee Act of 1980.

BEST COPY AVAILABLE

HHS State Legalization Impact Assistance Grants (SLIAG)

The Immigration Reform and Control Act of 1986 (IRCA) reimbursed states for certain education costs related to undocumented immigrants granted amnesty under the act. In addition, applicants for legalization were required to pass an English and citizenship test, entailing a minimum 40 hours of instruction. Services allowed under IRCA are those listed in the Adult Basic Education Act, including the required English language and citizenship training, literacy training, basic education, GED preparation, educational materials, curriculum development, ancillary services such as child care and transportation, and direct and indirect administrative costs. Administrative costs for a state education agency were capped at 1.5 percent.

The SLIAG education funds were not permitted to be used for job training or vocational education, and only limited funds were available for elementary and secondary school students and for adults. IRCA applied the definitions and provisions of the Emergency Immigrant Education Act, thus capping funds to a service provider at $500 per eligible child or adult per year. Funding for grades K-12 was not available for schools with less than 500 eligible individuals, or 3 percent of a school district's enrollment.

States were allowed flexibility in allocating SLIAG funds among public assistance, public health, and educational services (with a minimum 10 percent for each category). California used 20 percent of its SLIAG grant or education programs, doubling the state's ESL capacity and eliminating waiting lists for classes. However, when SLIAG funds end, California expects to support only 15 percent of its expanded capacity. Other states have recorded continued high enrollment in adult education classes by this population. SLIAG funds created a temporary capacity for educational services, but the demand and need for services continues. The English and civics requirement brought hundreds of thousands of people into the educational system for the first time. For example, a California survey of the newly legalized found that one-half were first-time users of educational services. Furthermore, the educational needs of the newly legalized are high. The INS Legalized Population Survey found that legalized aliens had substantially fewer years of education on average (seven years) than U.S. residents (13 years). While 85 percent reported speaking Spanish well, only 15 percent reported speaking English well.

A research project conducted in 1992 for California Community Colleges found that the amnesty population was unique, with different backgrounds and support needs from other groups who receive ESL in California community colleges.* The amnesty population's recent arrival to the educational process and their interest in support services suggests a considerable need for assistance in obtaining access to the system. The report recommends continued assessment and adjustment of instructional programs to serve the wide variety of educational backgrounds and ethnic diversity of the state's rapidly growing ESL population. The report also recommends programs that can educate immigrant parents and children together, providing educational opportunities for both adults and children and minimizing the inter-generational conflict of two languages and two cultures within the family.

HHS Office of Refugee Resettlement (ORR)

The Office of Refugee Resettlement within HHS is the agency responsible for domestic resettlement assistance for refugees. Two ORR programs allow states to use funds for employment and training: the Social Services program and the Targeted Assistance program.

A third program provides matching grants (up to $1,000 per refugee) to voluntary agencies for employment services, English language instruction, social adjustment services, food, and housing during a refugee's first four months in the United States. Refugees served by this program may access publicly funded medical assistance and other services.

ORR has also instituted demonstration programs funded from the social services appropriation ($12.5 million in FY 1992). This includes the Wilson/Fish Demonstration projects and the national discretionary projects (such as the Key States Initiative and Job Links).

Social services. The Refugee Act permits states to use funds in this program for a broad range of services, including any service allowable in a state's plan under Title XX of the Social Security Act, plus services allowed by ORR such as English language

SLIAG in Brief

The Immigration Reform and Control Act of 1986 (IRCA) was enacted to control illegal immigration. It established employer sanctions for hiring undocumented people, and granted amnesty to 2.6 million undocumented immigrants already in the United States. These newly legalized immigrants were barred from accessing federal programs such as AFDC and Medicaid for five years. (The bar ended in May 1993.) The State Legalization Impact Assistance Grants (SLIAG) program was created to reimburse states for public assistance, public health, and education costs related to this population during the five-year bar. In an unusual budgeting formula, federal funding of $4 billion was appropriated for FY1988-1991, to be spent by states until FY 1994. However, federal budget deficits have led to funding deferrals since 1990. The final appropriation of $812 million was allocated to states in FY 1994.

training, job development and placement, career counseling, vocational training, child care, and translation and interpreter services. However, ORR requires that if a state's refugee welfare utilization rate is 55 percent or more, 85 percent of social service funds must be used for English language training, vocational training, employment counseling, and job placement. The limitation does not apply if the social services plan was established by or in consultation with local governments, and provides for the maximum appropriate provision for employability services.

The remaining 15 percent may be used for orientation, social adjustment and translation, transportation, day care and other state Title XX services. Awards are made to states based on per capita arrivals for the previous three years. In 1992, Congress appropriated $83 million for the social services line item. ORR allocated $67 million to states; $3.5 million was earmarked for refugee associations; and $12.5 million was used by ORR for discretionary social service programs.

Targeted Assistance program. The Targeted Assistance program funds employment and other services for refugees and entrants in "high-impact" areas, e.g., counties with large refugee or entrant populations, a high proportion of refugees or entrants to the overall population, and high public assistance use. The goal is to assist refugees to obtain employment within one year. Eighty-five percent of the funds must be used for employment-related services (vocational English, on-the-job training, job placement). In 1992, $49 million was allocated for targeted assistance activities for refugees and entrants. Ninety percent was awarded to 20 states for 44 qualifying counties facing extraordinary resettlement problems; 10 percent was awarded to localities in 22 states most heavily affected by refugees such as Laotian Hmong, Cambodians, and Soviet Pentecostals, including secondary migrants.

An example of a successful program funded by Targeted Assistance is the Jeffco Employment and Training Services program in Golden, Colo., funded since 1986, and awarded a County Achievement Award from the National Association of Counties. Laurie Bagan, the state refugee coordinator, notes that refugees tend to have many employment barriers: low English skills, cultural differences, lack of training and experience, limited access to transportation, and lack of knowledge of the community and resources. The program's goal is to coordinate services among agencies and increase refugee access to existing programs. The program provides comprehensive and centralized services, including classroom training, work training experience, and support services such as day care and translation.

Demonstration Programs and Discretionary Projects

Wilson/Fish demonstration projects. In 1984 Congress directed HHS to examine alternative resettlement strategies for the delivery of cash assistance, social services, and case management to assist refugees make the transition from public assistance to self-sufficiency. Demonstration projects received no additional allocations; programs are funded from existing cash and medical assistance grants and social services grants.

The Oregon Refugee Early Employment Project (REEP), begun in 1985, is an alternative employment project to the mainstream refugee resettlement effort. It serves refugees ineligible for AFDC or SSI. REEP services are "front-loaded," that is, services are concentrated on the refugee immediately after

arrival in the United States. The program integrates services (language training, pre-employment training, job placement, child care, transportation) and provides linkages between service providers. (It is staff intensive, with only one caseworker for 35 cases.)

The REEP goals are early employment and increased self-sufficiency with cost savings to the program. An evaluation by the Refugee Policy Group found that REEP reached its objective of placing 75 percent of its employable clients in full-time permanent employment within 18 months of arrival in the United States. Family self-sufficiency (family earnings exceeding program income standards) was not achieved; a single wage earner at minimum wage could not support a family. It was hoped that future earnings would be higher as the earner gained work experience, or the family was supported by multiple wage earners. Cost savings of 18.5 percent were achieved over a three-year period. A follow-up review in 1991 noted that despite changes in caseload and reduced program length, REEP still showed that most refugees became employed within nine months of arrival.

Key components of the program are cash assistance, case management, and employment services contracted to three voluntary agencies and a consortium of refugee associations and medical assistance provided to all low-income clients through a full service medical provider. The program is monitored by Oregon state officials.

Other Wilson/Fish programs include a U.S. Catholic Conference demonstration project in San Diego, a grant to the Cuban Exodus Relief Fund,and demonstration projects with Alaska Refugee Outreach and in the state of Kentucky. (The California Refugee Demonstration Project existed from 1985-90.)

National discretionary projects. ORR allocated $12.5 million in FY 1992 for six programs directed toward improving employment opportunities for refugees: (1) the Key States/Counties Initiative aims to increase employment and reduce welfare dependency among targeted populations in New York, Minnesota, Wisconsin, Washington, Massachusetts, and Michigan (funded at a total of $2.5 million), and in Los Angeles County and Orange County ($400,000 total, funded under Targeted Assistance); (2) Job Links ($3.6 million) provides supplementary social service funds to 30 states with good resettlement opportunities to link refugees with jobs; (3) Planned Secondary Resettlement ($1.2 million) provides opportunity for unemployed refugees to relocate to communities with favorable employment prospects; (4) the Amerasian Initiative ($2.8 million) assists in resettlement of Amerasians and families; (5) Microenterprise Development Initiative ($1.3 million) to promote small business and self-employment among refugees; and (6) $1 million to 24 states and California counties for the special needs of Vietnamese re-education camp detainees.

Discussion

Coordination

A multiplicity of programs exist for employment and training. At the federal level, the GAO found 125 programs spending $16.3 billion to train adults and out-of-school youth, under the supervision of 14 federal departments or agencies. In Massachusetts, the National Commission for Employment Policy found 31 training programs funded at $320 million in FY 1992: 13 funded by the federal government, nine by the state, and six funded jointly by federal and state government (two were funded by other sources and information was unavailable for the adult education program). Of 31 programs, five provided 67 percent of the funds: JOBS, 26 percent; Vocational Rehabilitation of Massachusetts, 14 percent; JTPA II-A, 11 percent; Department of Mental Retardation, 10 percent; and Employment Services, 6 percent. An estimated 422,000 people were served.

As one method of maximizing dollars in a time of scarce resources, programs have been urged, or mandated, to coordinate services with other programs. Both JOBS and JTPA contain this type of language. Program coordination alone, however, cannot make up for the overwhelming demand for employment and training services. Nor does it answer how mainstream programs, attempting to serve a broad range of disadvantaged people, can serve those functioning at low literacy levels and/or those without adequate English language skills.

In the field, practitioners contend that they face "one-way coordination"; for example, no directives exist to require educational agencies to coordinate with JTPA. In addition, conflicting eligibility requirements and definitions of "economically disadvantaged" prohibit meaningful coordination of policies and programs. Uniform terms and definitions would simplify program administration

for both agencies and clients, for intake, assessment, planning, and evaluation.

Some areas have attempted to address this issue. For example, New Jersey has established a "super council" to streamline planning and delivery of employment and training programs. Created from the JTPA State Job Training Coordinating Council, the new State Employment and Training Commission makes policy recommendations to the governor on JTPA, Carl Perkins Vocational Education, Wagner-Peyser employment service, JOBS, and state programs. Since its creation, New Jersey has consolidated its education and training programs from 64 to 15, with a projected savings of $6 million over 18 months.

The Minnesota Interagency Adult Learning Council encourages those at the local level to coordinate services, for example, using a common intake form for welfare, employment and training, and community services. A 1985 law encouraged agencies to co-locate for one-stop shopping.

In California, if a county is already able to serve all AFDC participants, it may use federal refugee funds to set up employment programs or language classes for refugees within GAIN (California's JOBS program). State legislation allows counties to set up a parallel system to streamline a program for newly arrived refugees

In Tacoma, Wash., El Centro de Latino developed a collaborative program to provide ESL to Hispanics, particularly adults. It is supported with a variety of resources: city funds, school district funds and assistance in establishing an alternative high school, a grant from the Department of Labor, and assistance from Microsoft, Nintendo and IBM. The computer companies created a computer lab to train people in data processing and computer skills, and also established a family learning center for ESL.

In Atlanta, Ga., the Atlanta Private Industry Council (PIC) collaborates with Georgia State University to offer a Vocational English as a Second Language program to accommodate participants who do not have the skills necessary to enter the PIC's vocational training. The project is funded with JTPA education and coordination grant funds. This program serves Title II-C youth and operates six months each year.

Mainstreaming v. Targeted Programs

Participants in the Immigrant Policy Project's regional meetings examined the possibility of adapting "mainstream" programs that command larger resources, such as JTPA, to address the unique needs of refugees and immigrants. Research studies have demonstrated the high level of participation by immigrants in the workforce; refugees and some immigrants, however, need transitional assistance to facilitate their entry into the labor market. These newcomers generally need the same kinds of services that other disadvantaged populations need, with the unique requirement for English language instruction and cultural adjustment. For example, refugees need ESL classes, vocational/technical training, culturally specific employment and training, and support services (such as day care, counseling, and medical assistance). However, few refugees end up in mainstream programs and state-local resources are insufficient. Provided sufficient funds remain for targeted programs, these resources could be used to leverage mainstream programs and improve access by immigrants.

An argument against the creation of "targeted" populations is that it often becomes a screening device rather than a mechanism for inclusion. If programs serve only 5-10 percent of the eligible population, then 90-95 percent must be excluded, or turned away, from services. The current system is a patchwork of employment and training programs for specific populations with many holes and little coordination of services, eligibility requirements, or bureaucracies.

Other participants argued that mainstream programs are not equipped to accommodate the special language and cultural differences of immigrants, and that programs are still needed for those that do not qualify for mainstream services. In Minnesota, for example, the JTPA and refugee programs are operated separately to handle language, cultural, and discrimination issues.

In JTPA and other mainstream programs, refugees or other immigrants may not have as high a priority as other "targeted" groups for services. To focus attention on the needs of refugees and immigrants, policymakers may work within the SDA/PIC structure where most determinations on client groups are made; or state legislation can establish

priorities for JTPA, even at the SDA level. At the state level, recommendations and information on the needs of refugees and immigrants should be provided to the federally mandated boards such as the State Job Training Coordinating Council, the AFDC/JOBS Board, the Unemployment Insurance Board, and the Vocational Education Board. (Under 1992 JTPA amendments, states have the option to combine planning and delivery of employment and training programs under Human Resource Investment Councils.)

Job Corps, as a comprehensive, integrated provider of training, remedial education, health care, counseling, and support services may be a useful model or service deliverer for refugees and immigrants.

La Cooperativa, a Sacramento-based coalition of five organizations (including CET) that has trained low-income people for 25 years, observes that workforce development as a national issue is a serious problem. Eighty-two percent of the newly legalized population works, but public policy is geared toward dependent poor people and does not build on the strong work ethic of this population. While this population could fit into the community college system in California, they probably won't because of their low educational levels and difficulty in accessing public institutions.

Licensing of Foreign-born Professionals

An unexpected finding was the need to address U.S. certification and licensing requirements for foreign-born professionals. Highly educated refugees and immigrants are encountering barriers entering the workforce because foreign credentials don't transfer easily to the United States. In some areas, states and localities have developed programs to assist foreign-trained professionals with U.S. accreditation, for example, to alleviate physician and nursing shortages. PHASE was established in 1988 and funded by the New York City Department of Employment, in collaboration with the city Health and Hospitals Corporation and the state Office of Mental Health. PHASE assists immigrant professionals to become licensed or certified in occupations when a shortage has been documented in health or human services fields.

In testimony before the New York Legislative Commission on Skills Development and Vocational Education, Dr. Rosa Gil of PHASE stated that barriers to immigrant participation in the workforce include inadequate knowledge of professional credentialing requirements in the state, and unfamiliarity with U.S. testing methods. She recommended funding for ethnic community-based organizations to provide orientation, training and employment services; innovative on-the-job training for Hispanic, Asian, and Caribbean immigrants; and information for immigrant professionals on licensing, education and training programs, case management services, and employment services.

In Virginia, state officials are examining the possibility of licensing reciprocity with other states and the establishment of uniform standards for the health profession.

Florida established the following guidelines for physician certification. Any foreign doctor may become a physician's assistant if he or she: (1) practiced in his or her home country; (2) resided in Florida for three years before entering the program; (3) attended one year at the University of Miami; (4) and has one year of supervised practice by a Florida doctor.

Brown University has a one-to-one program for engineers that uses technologically specific English training and includes preparation for certification. In Chicago, a nonprofit organization provides training in both English and medical classes to pass the nursing certification (funded by SLIAG). This provides refugees with a guaranteed job as a bilingual medical professional. Another group provides scholarships to bilingual substance abuse counselors to pursue the two-year certification process.

The New York Association of New Americans (NYANA) developed an initiative to retrain Soviettrained nurses and help them pass the New York licensing exam by providing remediation in English with additional nursing instruction. This program fulfilled two objectives by providing employment for foreign-trained professionals and addressing a severe labor shortage of nurses in the city. The initiative continues as the New York State Health Transition Initiative with resources provided by the New York departments of social services, education, and health.

Eligibility for Services

The proliferation of immigration categories and differing eligibility for services created by the federal government has confused and complicated

the delivery of services to those who need them. Dr. Philip Martin of UC-Davis writes of "mixed families" created by the 1986 amnesty program, particularly for the agricultural workers. How should social policy deal with a family containing a legalized father (temporarily barred from services), unauthorized mother and children (ineligible for most services), and U.S.-citizen children (eligible for all services)? This is compounded by varying eligibility requirements in federal programs.

Georges Vernez of RAND recommends that the federal government standardize requirements for existing federal, social, and other entitlement programs for which immigrants are eligible. At the local level where services must be provided, many believe that distinctions of legal status are irrelevant: a person without a job, whether legal, refugee, or other, still needs assistance, but federal benefits are often lacking.

Communication Issues

In general, there is a shortage of interpreters, translators, bilingual teachers, ESL teachers, and ESL classes. Paul Hill of the RAND Corporation, in a discussion of newcomers in American schools, notes that the teacher supply is the greatest limiting factor in meeting the needs of immigrant students. Other unmet needs include texts and instructional materials, adult education for older immigrant students, and incentives for teacher mobility and training.

In Illinois community colleges, 45 percent of students are limited English proficient, but only 3 percent of the adult education budget is for ESL. There are insufficient teachers and number of hours provided for adult ESL classes. In California, CET has served 50,000 people in its English language classes through SLIAG funds; with the end of the program in sight, no replacement funds have been found to meet the enormous need. CET notes that the two components that offer long term benefit for the amnesty population are language development integrated with employment and training. The New York Association for New Americans (NYANA) notes that for Soviet refugees in their program the single most important determinant of their ability to obtain work is the ability to communicate in English.

We need and don't have a well-coordinated system that addresses language education and vocational training. The National Center for Research in Vocational Education states in a recent report that the long-term language instruction needs of immigrants are not provided for. Many immigrants cannot meet the ability-to-benefit testing criteria of JTPA or JOBS. The lack of bilingual training or support services is a barrier to the participation of immigrants in JOBS and JTPA. Finally, programs tend to "cream" at admission, choosing students most likely to become employed, because reimbursement is based on high job placement rates.

Availability of Services

Vernez writes that immigrants' demand for adult education (literacy, English, and vocational education) may be outstripping the ability of states and districts to provide. He states, "Adult education has been, and continues to be, the most-neglected area of education, not only for immigrants, but for all adults." The future economic prospects of the newly legalized depend on access to basic adult education; for example, nearly two-thirds have such low proficiency in English they would have difficulties functioning in other than entry-level jobs, in most job training programs, and in the community.

Local jurisdictions are finding it increasingly difficult to pay for immigrant services. Vernez finds this pattern: "The fiscal burden of immigrants increases as the size of the jurisdiction decreases, ranging from neutral or even positive at the national level, to neutral to negative at the state level, to negative at the local (county/city) level." Vernez recommends targeted federal funds for those communities most affected by new immigrants and their children, primarily for educational institutions—from early childhood to K-12, adult education, and community colleges.

Conclusion

The high immigration levels of the 1980s have been widely publicized: nearly 9 million newcomers accounted for one-third of the nation's net population growth. What has been less well considered is the Department of Labor's projection that immigrants will become a significant proportion of the nation's workforce.

These changing demographics will require some rethinking of the delivery of education, employment, and training to traditional and nontraditional U.S. workers. The existing employment and

training programs form a fragmented system, lacking adequate funds or resources. JTPA and JOBS programs have shown some success, but serve only a small percentage of the eligible population, and effectively discourage access by immigrants and refugees. The SLIAG program, which created temporary capacity for educating the newly legalized, is anticipated to end in September 1994. No preparations have been made to meet the continued demand for services of the 2.5 million newly legalized. The refugee program, which provides short-term employment services to a small portion of newcomers, has faced repeated funding cuts in recent years, and is again up for reauthorization and reform in 1994.

In a related arena, President Clinton promised to "end welfare as we know it" and replace it with a new system of welfare to work. Addressing the needs of the nonnative eligible public assistance recipients will be a challenge in federal, state, and local welfare reform efforts. Many Washington-based immigrant policy specialists have been surprised to answer federal inquiries on barriers of immigrants to family self-sufficiency. Refugees and immigrants, while still a small portion of AFDC recipients nationwide, confront unique barriers, particularly those of language and culture. However, many of the needs of immigrants and refugees are the same as other low-income families. Support services such as health care and child care are essential to a family's sustained independence from welfare.

A new social contract is being created between mainstream public assistance recipients and the government, giving each responsibilities. Government's side of the bargain is to ensure that the appropriate program support—such as classes in English as a second language, bilingual educators, and acculturation within government programs and the workplace—is available to support the welfare-to-work transition for targeted as well as mainstream populations.

As policymakers at federal, state, and local levels craft reforms of their welfare, education, employment and training programs for improved self-sufficiency and workforce skills, the requirements of a growing immigrant population will need to be examined and addressed. Successful practices within the programs discussed in this paper should not be overlooked; for example, combined language and vocational training, comprehensive services such as Job Corps, and coordinated services that address family self-sufficiency. In order to compete in today's global economy, the United States must invest in its most valuable asset, its workforce.

Notes

1. Eric S. Rothman and Thomas J. Espenshade, "Fiscal Impacts of Immigration to the United States," *Population Index* 58, no. 3 (Fall 1992).

2. U.S. General Accounting Office, *Job Training Partnership Act: Racial and Gender Disparities in Services*, GAO/HRD-91-148, September 1991.

3. "The National JTPA Study: Title II-A Impacts on Earnings and Employment at 18 Months," (Bethesda, Md.: Abt Associates Inc., May 1992).

4. James Riccio and Daniel Friedlander. *GAIN: Program Strategies, Participation, Patterns, and First-Year Impacts in Six Counties*, May 1992; and, Daniel Friedlander, James Riccio and Stephen Freedman. *GAIN: Two-Year Impacts in Six Counties*, (New York: Manpower Demonstration Research Corporation, May 1993).

5. Judith M. Gueron, *From Welfare To Work: Summary*, (New York: Manpower Demonstration Research Corporation, 1991).

6. Marta Elisa Moret, speaking at "Latino Families, Poverty and Welfare Reform" seminar sponsored by the AAMFT Research and Education Foundation, Washington, D.C., September 25, 1992.

7. Miren Uriarte, *Latinas in the Massachusetts Employment and Training (ET) Choices Program*, (presentation at "Latino Families, Poverty and Welfare Reform," seminar sponsored by the AAMFT Research and Education Foundation, Washington, D.C., September 25, 1992).

8. Scot L. Spicer and Jorge R. Sanchez, *Caught in the Shadows: Immigrant Educational Access—The Amnesty Population*. (Glendale Community College, Calif., April 1992).

References

Abt Associates Inc. *The National JTPA Study: Title II-A Impacts on Earnings and Employment at 18 Months*. Bethesda, Md., May 1992.

American Public Welfare Association. "State Views on AFDC, JOBS Issues," *W Memo* (January 1992): 9-20.

California Assembly Office of Research. *Ready or Not, Here We Come: Training California's Emerging Workforce*. Sacramento, Calif., June 1990.

Friedlander, Daniel; James Riccio; and Stephen Freedman. *GAIN: Two-Year Impacts in Six Counties*. New York, N.Y.: Manpower Demonstration Research Corporation, May 1993.

Gueron, Judith M. *From Welfare To Work: Summary*. New York, N.Y.: Manpower Demonstration Research Corporation, 1991.

Handelman, Mark, and Alfred P. Miller. "Vocational Services in Soviet Jewish Resettlement: The Challenge for the Nineties," *Journal of Jewish Communal Service* 67, no. 2 (Winter 1990).

Liddell, Scott. "New Jersey's Super Council Coordinates Workforce Development," *NCSL Legisbrief*, no. 16 (April 1993).

Martin, Philip. "NAFTA, Migration, and U.S. Labor Markets." Appendix C of *The Employment Effects of the North American Free Trade Agreement: Recommendations and Background Studies*. Washington, D.C.: National Commission for Employment Policy, 1992.

Meisenheimer, Joseph R., II. "How Do Immigrants Fare in the U.S. Labor Market?" *Monthly Labor Review* (December 1992): 3-19.

National Commission for Employment Policy. *Assessing State-Level Job Training Coordination: A Survey Design and Methodology Based Upon the Massachusetts Experience*, Research Report No. 92-01 (December 1992).

National Governors' Association. "Side by Side Comparison of the Job Training Partnership Act Before and After the 1992 Amendments." *Legisline* (October 1992).

National Immigration Law Center. *Guide to Alien Eligibility for Federal Programs*. Los Angeles, Calif., 1992.

Ramsey, Kimberly, and Abby Robyn. *Preparing Adult Immigrants for Work: The Educational Response in Two Communities*. National Center for Research in Vocational Education, University of California, Berkeley. #N-3586-NCRVE/UBC/RC. RAND, Santa Monica, Calif., 1992.

Refugee Policy Group. *The Refugee Early Employment Project: An Evaluation*. Washington, D.C., August 1989.

Refugee Policy Group. *The Refugee Early Employment Project: A Revisit*. Washington, D.C., May 19, 1991.

Riccio, James, and Daniel Friedlander. *GAIN: Program Strategies, Participation, Patterns, and First-Year Impacts in Six Counties*, New York, N.Y.: Manpower Demonstration Research Corporation, May 1992.

Rothman, Eric S., and Thomas J. Espenshade. "Fiscal Impacts of Immigration to the United States," *Population Index* 58, no. 3 (Fall 1992): 381-415.

Spicer, Scot L., and Jorge R. Sanchez. *Caught in the Shadows: Immigrant Educational Access—The Amnesty Population*. Glendale Community College, Glendale, Calif., April 1992.

U.S. Congress, House of Representatives, Committee on Ways and Means. *Overview of Entitlement Programs: 1993 Green Book*. 103d Congress, 1st sess., July 7, 1993.

U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement. *Refugee Resettlement Program: Report to the Congress*.. Annual Report FY 1992 Washington, D.C. January 31, 1993.

U.S. Department of Justice, Immigration and Naturalization Service. *Immigration Reform and Control Act: Report on the Legalized Alien Population*. March 1992.

U.S. Department of Labor, Bureau of International Labor Affairs. *The Effects of Immigration on the U.S. Economy and Labor Market, Immigration Policy and Research Report 1*, 1989.

U.S. General Accounting Office. *Job Training Partnership Act: Racial and Gender Disparities in Services*. GAO/HRD-91-148. September 1991.

U.S. General Accounting Office. *Job Training Partnership Act: Actions Needed to Improve Participant Support Services*. GAO/HRD-92-124. June 12, 1992.

Uriarte, Miren. *Latinas in the Massachusetts Employment and Training (ET) Choices Program*. Presentation at "Latino Families, Poverty and Welfare Reform," seminar sponsored by the AAMFT Research and Education Foundation, Washington, D.C., September 25, 1992.

Vernez, Georges. *Needed: A Federal Role in Helping Communities Cope with Immigration*. RAND Program for Research on Immigration Policy. RAND/RP-177. RAND Corp., Santa Monica, Calif., 1993.

Vialet, Joyce, and Larry Eig. "Alien Eligibility Requirements for Major Federal Assistance Programs." *CRS Report for Congress*. Washington, D.C.: Congressional Research Service, August 1, 1989.

Vialet, Joyce, and Larry Eig. "Alien Eligibility for Federal Assistance." *CRS Report for Congress*. Washington, D.C.: Congressional Research Service, April 27, 1993.

4. COMMUNITY RELATIONS AND ETHNIC DIVERSITY

Ann Morse
Jonathan C. Dunlap
National Conference of State Legislatures

Once I thought to write a history of the immigrants in America. Then I discovered that the immigrants were American history.

—Oscar Handlin

Chapter 4 was originally published as America's Newcomers: Community Relations and Ethnic Diversity *by the National Conference of State Legislatures, April 1993.*

INTRODUCTION

The United States was founded on the ideals of equal opportunity and individual freedom, embodied in the Declaration of Independence and symbolized by the Statute of Liberty. Millions have come from all over the world to pursue, and to fulfill, this dream.

Americans are strongly ambivalent about this migration to the land of the free. Compassionate to those fleeing war and persecution, Americans are also fearful that a large, unauthorized migration may jeopardize jobs, overwhelm government services, and destabilize communities. Periodically, the nation erupts in a public debate over newcomers and their effect on the social fabric. How do we ensure equitable and fair treatment to both newcomers and native residents? How can we separate the myth from reality and perception from fact about the benefits and the costs of immigration? Although most studies point to America's (and immigrants') overall success in assimilation, pockets of areas experience disproportionate impacts. These include highly visible areas with many, sudden arrivals, such as Florida's experience with Cubans and Haitians. Smaller communities are also changing, such as Lowell, Mass., whose population is now 20 percent Cambodian.

Recently, outbreaks of violence in several cities seemed to indicate that the nation is on the verge of ethnic strife: the melting pot was boiling over. Media and public attention on immigrants and race relations surged, heightened by the civil disorder in Los Angeles, the bombing of the World Trade Center, the Chinese boat refugees, and the Haitian exodus. People began to question whether the nation can successfully continue to absorb large numbers of the foreign-born.

Complicating the debate over immigration is the public's sense of competition for scarce resources. Two unrelated trends of the 1980s, high levels of immigration and economic restructuring, are creating ripple effects of unemployment, low tax revenues, limited budgets for social resources, and less available assistance at a time of increased need.

Federal jurisdiction over immigration policy limits the flexibility of states and localities to respond. With a steady decline in federal assistance, states and localities are faced with cutting back on programs and with meeting the needs of the native-born as well as the newcomers, raising issues of equity and community tensions. Finally, the federal government receives about two-thirds of immigrants' taxes, while states and localities receive only one-third of immigrants' taxes and provide the most services to them, particularly for education and health care. Areas facing both economic difficulties and high levels of immigration have petitioned the federal government to be more responsible for the consequences of its decisions in immigration policy.

The reality facing state and local policymakers is the need to provide basic services with few resources for communities made up of diverse ethnic and social groups, most of whom are legally residing in the United States. How do we cope with this diversity? What programs and policies can be created that are inclusive and responsive to the needs of both newcomers and established residents?

Researchers and policymakers alike point to the success of increased interaction and communication among community residents in easing tensions. For

example, all residents have a stake in safe neighborhoods and quality schools and can work together for these common goals. Policymakers can support good community relations in their roles as leaders in the community, as shapers of public opinion, and creators of policies and programs that equitably serve all community residents and that attempt to overcome the language and cultural barriers that often lead to tensions within the community.

This chapter examines problems and solutions in community relations between residents and newcomers, reviews the nation's historical ambivalence toward the foreign-born in public opinion and in legislation, and outlines the theories of assimilation (the melting pot metaphor versus the salad bowl metaphor). Practical examples of programs that successfully bring people together to solve common problems and ways that policymakers can build community from diversity are provided.

The Ambivalent Welcome

Since the earliest days of the republic, those already settled have cried out against those who would follow. Benjamin Franklin, while cognizant of the economic contributions of German immigrants, worried about their effect on the nation's linguistic and cultural unity. The Irish Catholics entering early in the 18th century were viewed as generally less desirable than earlier arrivals. Anti-immigrant sentiment led to the creation of a political party in the 1850s, the Know-Nothings, with one issue: opposition to immigration.

Legislation

The first federal laws pertaining to immigration passed in 1798, responding to the "alien menace" that might enter in the wake of th. French Revolution and the Reign of Terror. The Alien and Sedition Acts authorized the President to deport dangerous aliens and established a 14-year waiting period for naturalization. (The residence requirement for naturalization was restored to five years by the Jeffersonians in 1802 and has remained unchanged.) These laws reflected a heightened anti-immigrant rhetoric, and, as Ellis Cose suggests, they foreshadowed a regular pattern of xenophobia that resurfaces throughout American history.[1]

In the mid- to late 19th century businesses began to advertise overseas for laborers who would be willing to immigrate to the United States and work on the railroads, on farms, and in mines. However, as a significant number of non-European immigrants began to arrive in the United States, the nation began to impose limits on immigration. In the early 1880s, California passed laws excluding Chinese from immigrating into their communities. These laws were prompted by a depressed state economy and labor unions concerned about economic competition. Shortly thereafter, the federal government preempted these state immigration laws and passed the Chinese Exclusion Acts, a series of laws forbidding Chinese immigration and naturalization, and later expanded the ban to cover other Asians.

In the 1920s, a series of federal laws were enacted that placed severely restrictive quotas on immigration from all countries outside of Northern and Western Europe. In later years, the pendulum swung back. Congress eliminated race as a barrier to immigration in the 1952 Immigration and Nationality Act. National origin quotas were abolished in 1965 and replaced by a preference system for relatives of U.S. residents and workers needed in the United States. Current legislation permits 700,000 visas annually for family reunification and work regardless of country of origin.

Temporary entry, or "guestworker," programs were established by the federal government during World War II. The Bracero program encouraged immigration by Mexican agricultural workers to help harvest the nation's crops. In 1954, after the war ended and the farm labor shortage was over, the U.S. conducted a mass deportation program known as "Operation Wetback" in which hundreds of thousands of illegal farmworkers, resident aliens, and even some Mexican-American citizens were rounded up by federal law enforcement officials and deported to Mexico.[2]

Public Opinion Polls

"The current cohort of immigrants, whoever they may be, is viewed with suspicion and distrust," Rita Simon found after studying 50 years of public opinion.[3] In the late 19th and early 20th centuries, editorials and articles of many of the largest newspapers and magazines regularly opposed immigration by the newest immigrants, those from Eastern and Southern Europe, primarily Jews, Italians, and Slavs.[4] Today's "current cohort" of immigrants, those from Asia, Latin America, and

the Caribbean, are similarly opposed. A 1982 poll by the Gallup Organization indicated that Americans view the contributions of English, Irish, Jewish, German, and Italian immigrants more positively, while the contributions of the newest groups, Asians and Latinos, are viewed more negatively.[5] A 1992 poll by *Business Week* found that 69 percent of non-black Americans and 53 percent of black Americans believed that immigration is bad for the nation.[6]

And yet public opinion research also seems to indicate that the public's view of immigration may be favorably influenced by increasing the public's familiarity with different newcomer groups. In 1992, the American Jewish Committee surveyed Americans on the social standing of 58 different ethnic groups in the United States. European groups (the earliest immigrants) monopolized the top of the ladder, followed by Germans, Irish, and Scandinavians (arriving in the mid-19th century) and then by Italians, Greeks, Poles, Russians, and Jews. Notably, the ratings of all groups increased from 1964 to 1989, indicating that tolerance of ethnicity seems to be rising. However, the "Wisians," a fictitious group invented by the researchers, received one of the lowest scores. Most respondents did not rank the Wisians, but 39 percent of those surveyed were willing to offer the opinion that Wisians as a class were not doing well.[7]

The recent economic recession and subsequent slow recovery have also influenced the public's perception of immigration. Americans have been quick to blame immigrants for depressing wages and taking jobs from natives. Yet there is little economic research to support these fears. Most economic analyses have found that, in the aggregate, immigrant labor has little net negative effect on employment opportunities or wage levels for the native-born, and that over time immigrants are a boon to the economy.[8]

However, in isolated industries there have been some significant, short-term negative effects. Recent testimony before the federal Commission on Immigration Reform identified specific instances of displacement.[9] For example, citrus pickers in Ventura County, Calif., have been displaced by contract laborers who are undocumented immigrants. Likewise, construction workers in Houston, Texas, have suffered from competition with low-wage immigrant labor. Wages along the highly affected southwestern border of the United States also seem to be lower than in other regions of the country for comparable work. Finally, African-American janitors in Los Angeles have been displaced by Latino immigrant competitors.

Another negative influence on public opinion of immigrants is a belief that newcomers use too many public benefits and services. Newcomers are accused of burdening government budgets by overusing public programs, particularly welfare. The Urban Institute reports that immigrants' use of welfare is lower than commonly believed. "Only 2.3 percent of immigrants entering from non-refugee sending countries during the 1980s were reported to be using public benefits in 1989—lower than the welfare participation rate of natives (3.3 percent)."[10] However, certain groups of newcomers do use a disproportionate share of welfare services, such as refugees from countries such as the former Soviet Union, Vietnam, and Cuba who have experienced persecution and often need more public assistance than other immigrants.[11]

Certain segments of society are more likely to oppose immigration than others. Historically, those with less education or income and some racial minority groups have been more likely to oppose high levels of immigration because immigrants are viewed as competitors for resources such as jobs, housing, and benefits.[12] For example, polling data in the 1980s suggested that African-Americans are more likely to associate unemployment with immigration than are whites, Latinos, or Asians.[13] However, in the 1992 poll by *Business Week*, black Americans were more likely than non-blacks to support immigration and immigrants.[14]

Many U.S. citizens, particularly younger members of society (20 to 29 year olds), believe that the cultural diversity resulting from immigration is a source of the nation's strength. A nationwide Gallup survey in 1992 found that 61 percent of the public agreed that immigrants improve our country with their cultures and talents.[15] Muller notes that, in the abstract, Americans believe in cultural diversity, but they become less enthusiastic in times of rapid immigration and rapid development in the community.[16]

Melting Pot or Salad Bowl?

The "melting pot" is the traditional image of American assimilation of immigrants, representing a melding of peoples in a new nation bounded by

ideals rather than history, language, or culture. Newer theories of assimilation respect the cultures of origin and attempt to forge a balance between old and new: not a melting, but a mixing of a "salad" of unique ingredients. New York City's Mayor David Dinkins used "mosaic" to describe the city's variety of ethnicities and cultures. A recent study of U.S. immigrant children and how they assimilate calls into question whether the United States has one mainstream culture or a "rainbow" of social and ethnic mainstreams.[17] Lawrence Fuchs believes the metaphor that best captures the ethnic dynamics of assimilation is "kaleidoscope," expressing an extensive variety of color and shape and interrelationships that are complex and continually changing.[18]

These newer metaphors emphasize the idea of integration or accommodation rather than assimilation: newcomers adapt to the American mainstream, but they also change the communities they join. Rumbaut says, "The question for many immigrants is not whether they will assimilate. They will. But the question is, assimilate into what American mainstream or which American culture?"[19]

Bach notes that the traditional assimilation perspective "examines only the immigrants themselves, assuming that newcomers will adapt completely to established U.S. life."[20] Therefore, his Changing Relations Project focused on the accommodation, the process by which established residents and groups at different stages of resettlement found ways to adjust and support one another.

In *City on the Edge: The Transformation of Miami*, Portes and Stepick study the effect of the Mariel Cubans and Haitian refugees who arrived in Miami around 1980. Miami's population is now 49 percent Hispanic (60 percent of them Cuban), 30 percent non-Hispanic whites, and 19 percent black.[21] The authors argue that Miami is "the nation's first full-fledged experiment in bicultural living in the contemporary era."[22] Instead of adapting to American society, they write, the immigrants are transforming the city (see the sidebar "Changing Cities").

The traditional stages of assimilation may no longer occur: The first generation began at the bottom of the ladder and struggled, the second generation climbed, and the third generation attended a university and entered the American mainstream. Today, the increasing number and variety of ethnicities and cultures are having an effect on the "mainstream": the minorities are causing the majority to adapt. Some new arrivals don't start at the bottom of the ladder, but at the top, wealthy and educated, for example, in Monterey Park, Calif. Miami's Cuban community found an economic and political niche first, and only then began to adapt culturally.[23]

The effects of rapid transformation on communities can lead to racial or ethnic tensions. But defining or framing the problem of racial tensions can be difficult. Muller states that, in general, public anxieties about the current surge of immigrants are less economic than social, a concern that immigrant enclaves are culturally and psychologically separate from the American mainstream.[24] John Higham says that class culture is more important than ethnic or racial cultures.[25] Ngoan Le of the Illinois Division of Planning and Community Services finds that "what often divides people is economic well-being rather than race; racial differences are not as important as class similarities."[26]

Senator Art Torres of California sees opportunity in the newcomers' ties to their country of origin—as assets for international trade and economic development. One reason to value diversity is that it can work for the community, locality, or state by helping it compete in an increasingly interconnected global economy. The language skills and familiarity with a trading partner's culture can be tapped from immigrants to support new business ventures. The ease and low cost of transportation and communications facilitate ties between new and old cultures, and these ties can contribute to economic growth both in the United States and in the immigrants' country of origin. In 1984, when an immigrant family from Mexico started a wood-products company in San Diego, Calif., they were able to export a substantial amount of goods into Mexico because of their bicultural heritage and knowledge of Mexican business opportunities.[27] Similar cultural advantages have benefited California companies in Silicon Valley and other high-tech firms that are owned or operated by immigrants.

The Language Divide

Language differences are the major source of tension between newcomers and established residents. Bach finds that language serves "as a source of intergroup conflict, tension, and distance"

Changing Cities

Immigration since the 1960s has facilitated urban renewal, "by strengthening small businesses, providing low wage labor, and maintaining the population base necessary to sustain a high level of economic activity. The new immigrants—unskilled workers, professionals, and entrepreneurs—have encouraged the flow of investment, furnished workers for factories and service industries, and helped revive deteriorating urban neighborhoods."[27]

The composition of the population of U.S. cities has changed with the influx of immigrants in new proportions, as the following examples illustrate.

Atlanta: During the 1980s, Georgia experienced the most rapid increase of people who don't speak English at home, a gain of 113 percent. Blacks are Atlanta's largest minority group, at one-third of the city population of 2.8 million residents. However, the Asian and Hispanic population grew from 20,000 in 1980 to 200,000 in 1992.

New York City: Nearly one in three New York City residents is foreign-born. Almost a million are new immigrants, arriving during the 1980s. In contrast to other regions of the United States that receive primarily Asian and Mexican immigrants, the immigrants to New York City are mostly Caribbean and South American.

Monterey Park, Calif.: In 1970, two-thirds of the city's population was white; by the mid-1980s, the population was one-third white. Asians make up 57 percent of the total population of 61,000 in 1990, Hispanics 31 percent, and non-Hispanic whites the remainder.

Lowell, Mass.: One of seven residents is a recent immigrant. Cambodian refugees began arriving in the early 1980s, fleeing the Khmer Rouge and war in their homeland. By 1985, the community had grown to 3,000 people and established the first Buddhist temple on the East Coast, attracting even more Cambodians. Lowell is now home to more than 20,000 Cambodians, about 20 percent of the city's population.

Miami, Fla.: Miami's population is 49 percent Hispanic (60 percent of them Cuban), 30 percent non-Hispanic white, and 19 percent black. Even more dramatic is immigration to the county surrounding Miami: Dade County attributes 95 percent of its growth in the last decade to the foreign-born.

Total foreign-born in 1990: The foreign-born population of the United States was approximately 21 million in a total population of 258 million. In absolute terms, this is the highest number in U.S. history; but as a percentage, it is about half that of a century ago: in 1890 immigrants were 14.8 percent of the total population, and now they are about 8.6 percent.

Sources: Waldrop; City of New York; Muller (see References, p.65).

because people are unable to communicate with each other.[28] At the same time, language can serve as a primary method of bringing people together. Immigrants realize that the ability to speak English is the key to advancement and involvement in American society. The issue is not opposition to learning English, but the capacity to retain their first language in addition to learning English. In their recent study, sociologists Ruben Rumbaut and Alejandro Portes found that many immigrant children are quickly learning English, but they are also maintaining the languages and customs of their native lands.[29]

One myth about language is the belief that earlier immigrants adjusted without any special assistance. In fact, a number of private and public organizations organized and provided language classes for immigrants. New Jersey in 1907 passed legislation to support English and civics classes for the foreign-born. In New York, a Bureau of Industries and Immigration was established in 1910

BEST COPY AVAILABLE

to promote the effective employment of immigrants and their development as useful citizens. In 1914 the Federal Bureau of Naturalization sponsored citizenship classes in the public schools. Social clubs, labor unions, and businesses also supported language and civics classes for newcomers in the early 20th century.[10]

Linguistic and cultural differences are compounded and intensified by the institutional and residential segregation of different ethnic, racial, and economic groups that exists in American society today. Bach points out that the consequences of this segregation are that different ethnic groups have few opportunities to connect. "Groups interact in only a few special places, including schools, workplaces, churches, and playing fields. These are rare places, and each faces the excessive strain of absorbing and responding to the demographic diversity that characterizes America's communities."[11]

Barriers to communication and cultural misunderstandings between different ethnic groups can lead to isolation and polarization. New traditions and values are not automatically or easily accommodated. Often they are seen as competition, a threat to community stability, and previously established traditions. For example, when Asian businesses were created in Monterey Park, Calif., store owners put up business signs in their native languages. The prevalence of non-English signs in the business district was threatening to many Anglo and Latino natives who had lived in the community for many years. These residents responded by passing a law that required English signs, which created tension between the different communities.

However, in spite of the difficulties, community-building efforts are succeeding at easing tensions and building bridges between groups. The following section provides examples of policies and programs used by public officials, but more often by residents and newcomers themselves, to accommodate each other and solve common problems.

Coping with Diversity

State and local policymakers face the need to provide basic services with few resources for communities made up of diverse ethnic and social groups, most of whom are legally resident in the United States. This section provides practical examples for state and local policymakers to address the realities of a diverse multilingual, multiethnic constituency and help to build a community from this diversity. The examples and recommendations are drawn from a series of meetings conducted by the Immigrant Policy Project with state, local, and private representatives to discuss immigrant policy. At each of the meetings, the participants were invited to discuss community relations issues related to immigrants and the increasing diversity of the U.S. population. Discussions centered on roles for state and local policymakers, community representatives, and the media. Recent studies on community relations and newcomers are highlighted.

The examples and recommendations center on six broad areas: leadership, participation and community coalitions, citizenship, inclusive policies and programs, special offices or committees for immigrant issues, and media relations.

Leadership

Policymakers as public leaders have the ability to ease community tensions and provide responsive government. Because diversity is not naturally incorporated into the status quo, there is a need for elected and appointed officials to provide their constituents with a vision of the strength that comes from diversity and the common goals shared by newcomers and established residents. Interventions by policymakers are needed to help different ethnic groups work together and to help manage the newcomers' transition into American society without displacing existing communities.

State and local policymakers can provide this leadership in a variety of ways. An important first step is setting a positive tone for immigrant policy that emphasizes inclusion, equality of opportunity, and the recognition of the contributions of all residents. Officials can also work with the media to make sure that issues related to newcomers are grounded in facts and not emotion and prejudice.

Leadership of policymakers is interrelated with other components of this section: civic participation, coalition-building, and developing inclusive policies and programs. It warrants special attention because policymakers in their public role set the tone and image for welcoming newcomers and for assuring that government treats all residents equitably.

The leadership of public officials is a key element in developing and maintaining strong community relations among different ethnic and racial groups. Policymakers must be actively involved with each community to be aware of the stresses and conflicts there and to develop policies and methods for addressing problems before they become critical. Public officials can also take a role in teaching newcomers their responsibilities to their adopted community (such as health and safety requirements or housing ordinances) and through orientation to the community and to local government.

Other components of leadership involve promoting civic participation by community residents, such as encouraging citizenship, supporting coalition-building to solve common problems, and adapting policies and programs to reflect the diversity of the citizens being served, for example, in law enforcement, schools, housing, and health agencies. Political leaders have a key role with the media, communicating the success stories within the community and not focusing only on conflict.

Participation and Community Coalitions

"Participation works," states Robert Bach, author of a recent report, *Changing Relations: Newcomers and Established Residents in U.S. Communities.*[32] For this report, teams of researchers interviewed newcomers and established residents in six U.S. cities: Chicago; Miami; Monterey Park, Calif.; Houston; Philadelphia; and Garden City, Kan. The key to good community relations, they found, is to provide opportunities for groups of different ethnicities or cultures to work toward meaningful common goals. These activities should not focus on differences among groups, but on commonalities. Common goals, such as Neighborhood Watch or Safe Street programs, benefit all residents by improving schools, developing recreation programs for youth, and providing groups the opportunity to jointly solve problems. These types of community activities improve communication among groups and overcome perceptions of mistrust.

State and local policymakers are also in a position of bringing people and resources together to solve problems. This may include organizing meetings with government officials and various ethnic groups in the community, providing leadership training for newcomer communities to help them participate in local affairs, or facilitating cooperation among immigrant groups.

In New York City, former mayor David Dinkins worked with the New York Coalition on Immigration to bring representatives of the city's various ethnic groups together with the service providers who administer the city's programs. This meeting provided new information to city officials about effective service delivery strategies to these populations and encouraged newcomer communities to participate more actively in city business.

In Tacoma, Wash., former mayor Karen Vialle included immigrants and refugees in her organization of a Community Summit. Because Tacoma was trying to think creatively about its future, the mayor created a commission to define some goals for the community's next 10 years. The commission addressed eight issues, among them the environment, education, and the celebration and enhancement of cultural and ethnic diversity. Including the city's newcomers in this project gave them a sense of ownership in Tacoma's future and ensured that their concerns would be taken into consideration.

Frank Sharry of the National Immigration Forum notes that the current emphasis in interethnic relations is on conflict or dispute resolution, dialogue, and occasions to celebrate cultural diversity. Though these activities are a place to start, more meaningful kinds of cooperation, such as interaction and coalition-building around common interests, is needed. As an example of innovative coalition-building, immigrant communities in California have begun to unite with environmental groups to oppose industrial pollution in their neighborhoods.

Los Angeles' South Central neighborhood, where the civil disturbances of 1992 occurred, experienced a 16 percent population growth in the last 10 years, but only a 1 percent growth in housing. Ron Wakabayashi of L.A.'s Human Relations Commission notes that there is a great deal of competition for housing and other services. The suburban migration of the 1980s meant middle-income abandonment of inner cities across the country, leaving the poor and fixed-income residents. In many inner-city neighborhoods there is an absence or underdevelopment of a "social infrastructure," institutions that can define, frame, and mediate community tensions, and advocate community interests. For newcomers, it generally takes three generations to begin getting involved in political institutions and advocacy. Without

Recommendations of The Changing Relations Project

The Changing Relations Project investigated the relationships between recent immigrants and longer-term residents. The following are the project's recommendations to national, state, and local officials for fostering positive interactions between these groups:

1. A primary rule of policy should be to avoid actions that worsen relations among newcomers and established residents.
2. Policies such as the legalization program under the Immigration Reform and Control Act of 1986 should foster inclusion and participation of newcomers.
3. Newcomers with permanent residency status should be enabled and encouraged to participate in local elections, reinforcing efforts of coalition-building through local electoral participation.
4. Federal budgetary problems and the uniqueness of local combinations of groups require a renewed focus on community-building. Grass-roots organizing is a useful approach in promoting opportunities for interaction among groups at the local level.
5. Local activities should encourage participation and mobilization across group lines.
6. Existing organizations are not necessarily responsive to the new demographic, social, and economic diversity in today's communities. They should consciously seek ways to cross group boundaries and identify common projects.
7. Efforts should be expanded to provide newcomers with access to English-language programs, and established residents should be encouraged to learn other languages.
8. Established residents need more and better information about newcomers.
9. Media reporting often misrepresents the range of interactions and complexities of relations, especially in crises. Coverage should be continued until such incidents are resolved.
10. Special events and public festivals can create a more tolerant tone in communities and are particularly effective when they involve face-to-face collaboration among groups in planning the events.

The Changing Relations Project was a seven-year research project funded by The Ford Foundation. Principal author: Robert Bach.

institutions to channel or relieve stress and to solve problems, stress can escalate to a flashpoint. The question for policymakers is how to enable these underdeveloped community institutions and make diversity work.

For many public officials, Los Angeles symbolizes a "balkanization" of minorities, each community looking after its own interests. Public officials fear that this will occur in their cities and are seeking ways to be responsive to and support unity among different minorities. In Los Angeles, this process (sometimes called "building community") involves surveys and conversations with residents to frame what the community should be, how people belong to the community, and how the community belongs to the city. Ron Wakabayashi compares the city's stresses to the fault lines of an earthquake: we know where the stresses are and where we need to do initial intervention. But in the long term, we need to develop a social infrastructure and design it in a way that supports diversity.

Bach notes that there are complex problems related to inviting participation from many different groups. The "pervasive mismatch between the resources groups need and the current structure of available financing . . . is a primary reason efforts to organize intergroup relations fail."[33] These groups need connections with agencies, whether government, nonprofit, or for-profit.

Community coalitions need to encourage immigrants to represent their own interests, define problems, develop solutions, and participate in the decision making. Too often, the native-born decide what immigrants need. Mechanisms to encourage participation should include door-to-door flyers and announcing public meetings in multilingual newspapers.

In Washington, D.C., the National Immigration Forum established the Community Innovations Project to examine community relations between newcomers and established residents. This project

is founded on the belief that community relations are likely to be most successful when different *ethnic communities unite to pursue common goals*, focusing not on group differences but on shared interests. The project is assembling information on examples of interethnic cooperation in New York, Chicago, Los Angeles, and Washington, D.C. A forthcoming report will describe successful models that state and local officials can consider for their communities.

A new federal program for community service may also provide mechanisms for bringing diverse groups together. The Corporation for National and Community Service, created in September 1993, will strive to foster civic responsibility and strengthen the ties that bind us together as a nation through community service programs.

Citizenship

Lack of citizenship, and all that this privilege implies, contributes to the isolation of immigrants. Without citizenship and the right to vote, immigrants have no representation in local, state, or national government. Subsequently, immigrants are not connected to civic affairs. The INS estimates that there are 10 million legal residents in the United States who are not citizens.

To be eligible for United States' citizenship (or "naturalization"), an immigrant must be lawfully admitted for permanent residence and have resided in the United States continuously for five years. Applicants for naturalization must pass tests in English and civics and promise to obey the Constitution and laws of the United States. Citizenship confers the right to vote, to hold public office, and to serve on juries.

In November 1993, the Clinton administration proposed a new policy to spend $30 million to encourage legal immigrants to become naturalized United States citizens. For the first time, according to Sam Bernsen, a former INS lawyer, the federal government will actively encourage and promote citizenship for immigrants. The administration policy would allow INS to enter into cooperative agreements with community-based organizations, ethnic associations, and educational institutions to assist immigrants in preparing naturalization applications and in meeting civics and language proficiency requirements. Additional efforts will be made to streamline and simplify the administrative procedures of the naturalization process. INS Commissioner Doris Meissner puts it this way: "Naturalization builds bridges between new immigrant groups and the existing society, much as labor unions, political parties, and public schools have done in the past."[74]

Avoiding Racial Conflict

The U.S. Department of Justice's Office of Community Relations Service (CRS) helps communities to resolve disputes deriving from interethnic conflict. CRS staff have been called on to provide dispute resolution counseling and other techniques in crises such as the episodes in Brooklyn-Crown Heights, Washington, D.C.-Mount Pleasant, and South Central Los Angeles.

CRS publishes a guide to help state and local officials understand racial and ethnic conflict. Some highlights of the guide, entitled *Avoiding Racial Conflict: A Guide for Municipalities*:

> There are two community dynamics that lead to civil disorder: (1) a perceived disparity in treatment between groups and (2) lack of confidence in redress systems. When one or both of these dynamics are present, tensions are heightened and public displays of superiority, antagonism, or confrontation have the potential for triggering civil disorder.
>
> Proactive efforts on the part of state and local governments are important and cost-effective. These include instituting local redress systems that prohibit discriminatory behavior and punish offending officials and creating ordinances on civil rights, hate crimes, human relations commissions, fair housing, equal opportunity, and voting rights. Finally, it is important that all members of the community be represented on boards and commissions.

BEST COPY AVAILABLE

The Clinton administration policy is expected to help defuse anti-immigrant sentiment, enfranchise immigrants, encourage immigrants to increase their participation in civic affairs, and make it easier for immigrants to get jobs as police officers or public school teachers, which are limited to citizens in some states.

This effort will build on the model established by the amnesty provision of the Immigration Reform and Control Act. The undocumented who were granted amnesty were required to take English and civics classes to obtain legal residency. These classes encouraged the newly legalized to participate more fully in community life and brought both newcomers and established residents together. These three million legalized aliens are now becoming eligible for citizenship, having completed five years of legal residence in the United States.

Nongovernmental organizations also have a role to play in encouraging newcomers to become citizens. One example is the work of The Close Up Foundation, a nonprofit citizenship education organization. Close Up established a Program for New Americans in 1987 for high school students who have been in the United States for less than five years. Since 1987, more than 4,000 students from 30 states and 80 countries have participated. The program provides an understanding of the U.S. political and democratic process through the study of government at the local, state, and national levels. Students visit their state capital and meet with local leaders; visit Washington, D.C., and meet with congressional members or their staffs; and put their new civic participation skills into practice in a community service project.

Inclusive Policies and Programs

There are a number of specific policies and programs where state and local policymakers can implement change to be more inclusive of all residents in the community. Issues such as multilingual outreach, law enforcement, and economic opportunity are all important to developing honest, fair, and open community relations. All community residents, established and newcomer, should have the opportunity to participate in the development of policies and programs that serve them. Ron Wakabayashi notes that coalition- and community-building requires leadership to become more sensitive to including all communities and people of color, particularly those who have been traditionally disenfranchised and excluded from the economic, political, or social mainstream. Marcia Choo of the Asian-Pacific Dispute Resolution Center adds, "We often try to 'fix the problem,' or have already defined and framed the problems, issues, and solutions and yet leave out those whose lives will be most affected."

Multilingual outreach. To help newcomers adjust to their new communities and to integrate themselves into mainstream society, some localities are creating multilingual outreach programs, which provide an orientation to U.S. society to newcomers in their primary languages. Some outreach programs also help connect residents with their elected representatives.

The Arlington County, Va., Bilingual Outreach program is one such example. The program was created in 1981 to assist Southeast Asian refugees with limited English proficiency (known in education circles as LEP). The program mushroomed during the 1980s to include Hispanics and other LEP newcomers. The program employs five bilingual outreach workers who make home visits and hold small group meetings in multiple languages to teach newcomers basic home economics, basic health information, survival English, and the way to obtain needed social services. The outreach workers also teach classes about doing laundry, gardening, using energy wisely, and family planning. In 1992, Arlington County's program received a National Association of Counties Achievement Award and an Innovations Award from *Governing* magazine.

In Boston, Mass., former mayor Ray Flynn created the Neighborhood Services Liaison to be a "one-stop shop" for residents in need of community services. Each part of the city had a liaison in the mayor's office who was available through a 24-hour hotline to make sure that communities were receiving necessary services (i.e., street sweeping/plowing, streetlight repair, etc.). In other words, if something was wrong with a city-provided service, residents could call their Neighborhood Services Liaison, often in their primary language, and obtain assistance. This representation reassured many isolated and nonparticipating communities that they did have access to the system and that they could work with city government. A similar community liaison program in Miami, Fla., was instrumental in defusing community tensions there during the Los Angeles riots.

City of San Diego—Diversity Training

The City of San Diego implemented a program in 1991 in recognition and appreciation of the rich diversity of the city's 10,000 employees and 1.2 million constituents. The goal of "The Diversity Commitment" is to create an environment where differences are valued as assets and to create a high-performing team delivering better services to the city residents.

Information was collected in focus group interviews from nearly 1,000 city employees selected randomly and assured confidentiality. Diversity issues included equitable service, bureaucracy, leadership, performance measurement, rewards, career development, promotion, communication, health and safety, benefits, and inclusion and participation of people of color and white women in the organization. The city then identified career development, communications, and promotions as the areas most needing improvement. These data led to policy changes in the hiring and promotions process and the establishment of new mechanisms to deal with the identified problem areas.

Additionally, the city instituted four-day diversity educational sessions for employees on confidentiality, prejudice, harassment in the workplace, racism, sexism, gay and lesbian issues, the Hispanic experience, planning, support systems, and future actions.

The following specific changes were instituted by the city:

- Changed policies and procedures to ensure that all employees can feel productive and valued at work regardless of ethnicity, sexual orientation, physical disability, age, gender, family status, or religion, and to improve the delivery of services to the city's culturally diverse residents. Conducted problem-solving groups and action planning sessions to make short-term and long-term plans. Addressed issues such as communications with employees, removing barriers in the interview and promotion process. Distributed the city's equal opportunity policy to all employees; published it in both English and Spanish; and included an informational insert on sexual harassment.

- Instituted monthly meetings with employee associations (e.g., AFSCME) as well as informal city groups (e.g., the Latino Employees Association) and representatives from the fire and police departments' human resources divisions to discuss diversity issues.

- Created a mechanism between management, unions, and informal employee groups as a proactive system to raise diversity issues.

- Improved the selection procedure for hiring and promotional interview panel members to better represent employee/applicant diversity (e.g., multilingual, gender, ethnic, and age differences).

- Established new family issues and tuition reimbursement policies as a result of concerns raised during the diversity interviews.

- Created a Multicultural, Multilingual Task Force to address specific issues and make recommendations for change regarding language, accent, and translation concerns.

Language. Federal laws and court decisions require the provision of education and language services for immigrants. The 1964 Civil Rights Act prohibited "discrimination and denial of access to education on the basis of a student's limited English proficiency." Health, Education, and Welfare (HEW) regulations to implement the 1968 Bilingual Education Act required local districts to provide appropriate services to LEP students in order to receive federal aid. The 1974 *Lau v. Nichols* Supreme Court decision upheld the HEW requirements when it ruled that a Chinese student in San Francisco, unable to obtain instruction in his native tongue, was being deprived of equal educational opportunity. The 1982 U.S. Supreme Court case, *Plyler v. Doe*, established that a child should not be denied access to a public

elementary or secondary education because of immigrant status.

As previously discussed, language is the main cause of division among different ethnic groups. However, English classes in many states are severely oversubscribed. In New York City, federal, state, and local funding provides free English classes to approximately 30,000 students a year. But the 1990 census estimated 1.36 million New Yorkers have limited English proficiency. A survey of programs receiving federal adult education funds conservatively estimated that 17,000 people were on waiting lists for English classes in 1990.[7]

Michael Fix and Wendy Zimmermann of the Urban Institute find that "one-half of Miami's population, one-third of Los Angeles' population, and one-fifth of New York's population reported in the 1990 census that they do not speak English 'very well.'"[8] The number of LEP children in the schools rose 52 percent between 1986 and 1991, while school populations rose only 4 percent.

Providing opportunities and resources for immigrants to learn English is a necessity so that newcomers become employable and self-sufficient. In Massachusetts the state has instituted a program to promote opportunities for English in which part-time organizers recruit native English speakers to teach English to newcomers and help them prepare for the citizenship test. In Chicago, an intercultural family literacy program brings together Latino and African-American families to promote literacy.

Many states and localities have developed language banks, hired interpreters and translators, and/or contracted with a telecommunications service for translation assistance over the telephone. For example, New York City uses a variety of tools, including the telecommunications service; interpreters for the police department emergency service, who can handle calls in any language spoken in New York City; and a large pool of volunteers for city workers seeking translation services.

The Transitional Institute for New American Students is a demonstration model established in 1992 at the Caribbean Research Center of Medgar Evers College, City University of New York. Caribbean immigrants in New York experience the same problems as other immigrants: family disruption, culture shock, unfamiliarity with school systems, among others. But they also face academic and language difficulties. Although their home countries' official language was English, they have different levels of competence in English, and a special English skills development program is often needed. Their lack of formal education and low English proficiency causes poor performance in math and reading, in spite of high attendance rates. Three cornerstones of the project are the orientation package for students and families, parent involvement, and teacher sensitivity.

Law enforcement. To successfully apply the law and protect all residents of the community, law enforcement officials need to develop and maintain outreach with new ethnic communities. In Lowell, Mass., hiring minority police officers helped the city's large Cambodian population to feel more at ease with the police department. The city of Lowell was able to create these new positions in the midst of a city budget crisis through an innovative swap. The local housing authority was persuaded to spend a portion of its public safety appropriation to hire the Cambodians and to then lend them to the police department. In exchange, the police department took responsibility for protecting some of the public housing units.

Police departments must recognize special issues related to immigrants. Immigrants tend not to report crimes because of communication problems, cultural gaps, fear of U.S. immigration authorities, ignorance of their rights, and unfortunate experiences with the police in their home countries. For example, in cases of domestic violence, a battered spouse without legal status is unlikely to seek police protection for fear of deportation. Traditional healing practices are often misunderstood. One example is the Southeast Asian practice of "coining," in which a parent heats a coin, places it on a child's neck or back, and vigorously rubs the coin against the skin in the belief that this is an effective method of solving respiratory problems, infection, or sore throats. This process leaves burns or bruises on the skin and may appear to be child abuse in the eyes of the police and social workers.

In St. Paul, Minn., A Community Outreach Program (ACOP) has succeeded in building trust between the police and the city's Asian community and has lowered crime rates in the process. Created in 1991, the ACOP is the product of cooperation between the city's police department and public housing agency. There are four large public housing projects in St. Paul, 70 percent of which are occupied by Southeast

Asians. Before ACOP, the housing projects had high crime rates, and the police received little cooperation from the residents, who were reluctant to file police reports, aid investigations, or testify in court. With funding from the U.S. Department of Housing and Urban Development drug elimination program, St. Paul assigned some police to part-time patrols in the housing projects. By 1994, the ACOP program had seven full-time uniformed officers (including two Asian and one African-American officers), one police sergeant, three interpreters, two social workers, and one crime prevention specialist.

The police in ACOP intervene in the community to stop kids from joining gangs and to provide positive role models. Every officer in the program is assigned to a special detail such as leading a Boy Scout troop or coaching an athletic team. For adults there is a residential council for each housing project, which meets monthly with police and personnel from other city agencies. Adult residents may also participate in the ACOP advisory board council, which serves as a liaison between the police and residents. ACOP social workers are helping to bridge the gap between kids and parents by providing counseling and education, and working with police officers in some situations. ACOP also has a crime prevention program, which introduces residents to the police in their community, teaches the residents personal and property safety, and takes them on a tour of police department. Residents are also encouraged to ride along with ACOP officers on their patrols. Finally, ACOP officers and the project residents provide training to other city police officers about Asian culture and values. ACOP has resulted in better reporting of crime and major reductions in drive-by shootings, assaults, and gang activity. Although ACOP primarily serves the project residents, police report that even Asians outside the projects prefer to call the ACOP office first.

Economic opportunity. One area where immigrants and residents sometimes clash is over day labor and street vending. For poorly educated newcomers, this type of work requires little English proficiency and few job skills. However, merchants and local residents are often opposed to laborers and vendors congregating on corners in their communities while they wait for prospective employers or sell their wares. In Los Angeles, the Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA), in cooperation with the city, has started a project to meet the needs of both residents, laborers, and vendors. With a little seed money, the project provides for a more structured and organized system wherein the city provides portable toilets and trash cans, school and health officials provide on-site classes and health checkups, the laborers put their names on rosters for work, and street vending is better regulated.

Often, access to capital is the barrier to entrepreneurship for newcomers and residents alike. Many immigrant communities have been victimized by large banks that accept immigrant savings deposits but are unwilling to loan money to immigrant communities. In response to this credit crunch, Brooklyn, New York's Central Brooklyn Partnership, and a coalition of churches and community development organizations have recently created the Central Brooklyn Federal Credit Union. The Central Brooklyn FCU provides loans to residents for personal use and for cars, mortgages, education, home repair, and small business development. With a newly awarded federal charter, all deposits in the credit union are insured by the federal government for up to $100,000. The Central Brooklyn FCU is the only credit union exclusively serving Central Brooklyn and the Caribbean immigrants who live there.

Special Offices of Immigrant Affairs

Several states and localities have established offices, legislative bodies, city or county offices or liaisons, or advisory committees specifically to respond to issues related to immigrants.

The Virginia legislature established a Joint Subcommittee Studying the Needs of Foreign-Born Individuals in the Commonwealth (1992-1993). The legislature has examined the needs of immigrants for education, health care outreach, translation of government documents, and interpreters for civil cases.

California in 1993 established an Assembly Select Committee on Statewide Immigration Impact, chaired by Assemblywoman Grace Napolitano. Upon completion of five public hearings held around the state, the committee will issue a report of its findings in January 1994. (A previous committee fell victim to the 1991 budget crisis: the California Joint Committee on Refugee Resettlement, International Migration and Cooperative Development, which had been created in 1973. The committee was created to maximize federal support and establish effective state strategies to assure the

orderly socioeconomic integration of immigrants and refugees into California society.)

In 1987, the New York Assembly created the Task Force on New Americans to consider immigrant employment and civil rights, among other issues. In 1993, the assembly was forced to terminate the task force because of state budget deficits. In 1994, Assemblyman Brian Murtaugh, a senior member from Manhattan, went to the Speaker of the House and asked to recreate the task force using his own staff and personal resources. The task force's agenda for 1994 will focus on leveraging more funds from federal, state, and private sources to fund classes in citizenship and English as a second language (ESL) for the amnesty population; reviewing employer sanctions and evidence that they contribute to discrimination in hiring; and developing strategies to encourage immigrants to create entrepreneurial business ventures and become economically self-sufficient.

In 1986, Oregon Governor Neil Goldschmidt created an office to manage the Immigration Reform and Control Act's (IRCA) State Legalization Impact Assistance Grant. In 1987 this office became the Governor's Immigration Coordinating Committee by executive order. The committee has 13 members, appointed by the governor. The committee researches housing, employment, labor, and health issues relating to the newcomer population in Oregon. It also is charged with monitoring and implementing IRCA, recommending policy solutions to the governor on immigration-related issues, providing technical assistance on employer sanctions and other IRCA-related laws and regulations, acting as liaison with the INS, and serving as the state point of contact on all immigration issues.

In 1991, in recognition of Texas' large immigrant population, Governor Ann Richards and the Texas Legislature created the Governor's Office of Immigrant and Refugee Affairs (GOIRA) to develop and coordinate programs and policy affecting the newcomer population in Texas and to serve as the state's primary resource on all newcomer issues. The agency's mission statement is "to understand and address the needs of the immigrant/refugee population in Texas through policy development, distribution of public and private funds, coordination of services, and dissemination of information; and, to facilitate the self-sufficiency and social integration of Texas' immigrant/refugee population and to foster an understanding and appreciation of the state's cultural diversity." GOIRA is the first legislatively sanctioned state agency in the country dedicated to addressing immigrant and refugee issues.

In St. Paul, Minn., former mayor Jim Scheibel created an Advisory Committee on Refugee Affairs. Southeast Asians are the largest minority group in St. Paul, making up 7 percent of the population. The committee's "Report on Southeast Asian Family and Youth Issues" found that more than 60 percent of all Southeast Asians and 70 percent of Southeast Asian children live in poverty. The Hmong constitute 90 percent of the Southeast Asian population. Primarily a rural, seminomadic people, the Hmong face large cultural and educational barriers (a written Hmong language has existed only since the 1950s). Southeast Asians remain isolated from the mainstream community, linguistically, culturally, and geographically. Southeast Asian families are suffering from severe stresses to the family fabric. Immigrant children, because they adapt faster to the new language and culture, become the intermediaries for the family, creating role reversals where parents and grandparents rely on the children.

Media Relations

The media affect how the broader community understands newcomers and interacts with established residents; it is extremely important to highlight the positive aspects of communities and not just the crises. Community leaders complain that the media often mistake long-term residents of foreign descent for new arrivals, and that stories often focus on conflict, not the development of problems and efforts to cooperate and solve them. Media coverage is criticized for contributing to xenophobia by focusing on negative aspects of immigration, catering to stereotyping, and reporting none of the positive contributions of immigrants.

Bach notes that reporting tends to be episodic and crisis-oriented and rarely emphasizes the positive. Immigrant advocacy organizations argue that the media reinforce negative attitudes by regularly associating newcomers with increasing costs for public services (such as education, health care, and welfare), high unemployment and job displacement, and community tension and conflict. The media usually recognize a community's diversity only in times of social conflict and tension, associating diversity solely with negative results. As ethnic groups work together to solve some of these

problems, media coverage is notably absent, having already moved on to the next crisis. Newcomers' contributions, such as creation of small businesses and jobs, and values such as thrift, hard work, and self-sufficiency are rarely mentioned.

Los Angeles suffers from "communication segregation," according to Ron Wakabayashi, leading to different perceptions of problems. More than 80 different specialty presses exist in Los Angeles. Through the eyes of the *Los Angeles Sentinel*, you see a reflection of social history and a sense of injustice suffered by African-Americans and an expectation that the criminal justice system will not serve them fairly or treat them equitably. The *Korea Times* reflects a story of immigrants, of long hours in family operations, of the American dream. The role for policymakers is to help frame and define problems not as crises but as social histories and how these histories intersect.

Wakabayashi notes that because of the vast number of language groups, special populations, and media, it is difficult to develop adequate exchanges among communicators, so that the media can get a broad view. This wider perspective is an important foundation for cooperation among groups.

The Communications Consortium Media Center is a nonprofit organization that helps public interest groups make targeted and efficient use of the media as a means of bringing about policy or social change. The consortium, in conjunction with the National Immigration Forum, is conducting an Immigrant and Refugee Media Project. This project has assisted both advocates and policymakers in promoting the positive contributions of immigrants. Topics included explaining how broadcast and print media work, focusing and targeting a message, writing press releases, improving relations with reporters, developing a media list, and other media relations techniques.

One way to counteract negative media portrayals of immigrants is press conferences or photo opportunities that feature local leaders who are immigrants. Stories on family ties, respect for parents and grandparents, and a good work ethic also can contribute to common understanding, demonstrating that values are shared by newcomers and residents alike. Policymakers can contribute to good community relations by working with the editorial board of local newspapers to publicize success stories. Some media are reaching out to immigrant communities. For example, some of the Houston media initiated community meetings to develop cross-cultural programming for their station.

Conclusion

Americans traditionally have mixed feelings about immigrants: pride in ethnic heritage versus fears of job displacement and competition for resources. The current political and social environment reflects that same ambivalence. Though some would state that immigrants threaten the American social fabric, others argue that we can't afford to disenfranchise a large proportion of the nation's legal residents.

Federal proposals in Congress this year would curtail or bar access by certain classes of immigrants from federal assistance, mainly as a source of financing for welfare reform or for budget deficit reduction. These proposals contain the following assumptions:

1. Federal program ineligibility will induce immigrants (legal or not) to leave the country.
2. Federal assistance should not be extended to immigrants even if they have a disabling accident, suffer from domestic violence, or lack family or support networks.
3. A prohibition on federal benefits will require family members to support their immigrant relatives.
4. States and localities will continue providing services to residents who continue to need them, and they will tacitly accept and pay for the shift in responsibility for immigrant services.

However, an end to federal financial assistance for newcomer services does not in any way mitigate the newcomers' actual needs for services, or the state and local responsibilities for public health and public safety.

Ultimately, immigration is about our communities: our families, our neighbors, our co-workers. State and local policymakers hold key roles in developing and maintaining strong community relations among all residents. They provide leadership, promote inclusion, develop special institutions, and in effect, act as stewards of immigrant policy. Policymakers and community leaders continue to discover new ways of "building community from diversity" that support our founding ideals of equal opportunity and individual freedom.

NOTES

1. Ellis Cose, *A Nation of Strangers: Prejudice, Politics and the Populating of America* (New York, N.Y.: William Morrow and Co., 1992), p. 23.

2. Lawrence Fuchs, *The American Kaleidoscope: Race, Ethnicity, and the Civic Culture* (Hanover, N.H.: University Press of New England, 1990), p. 276.

3. Rita J. Simon, "Old Minorities, New Immigrants: Aspirations, Hopes, and Fears," *The ANNALS of the American Academy of Political and Social Science*, November 1993, p. 61.

4. Rita J. Simon and Susan H. Alexander, *The Ambivalent Welcome: Print Media, Public Opinion, and Immigration* (Westport, Conn.: Praeger, 1993), see pp. 71, 85, 127.

5. Simon, "Old Minorities, New Immigrants," p. 63.

6. Michael J. Mandel et al., "The Immigrants: How They're Helping to Revitalize the U.S. Economy," *Business Week*, July 13, 1992, p. 114.

7. Tamar Lewin, "Study Points to Increase in Tolerance of Ethnicity," *New York Times*, January 8, 1992, p. A12.

8. *See* Maria Enchategui, "Immigration and the Wages and Employment of Black Males," photocopied (Washington, D.C.: The Urban Institute, 1993); Eric S. Rothman and Thomas Espenshade, "Fiscal Impacts of Immigration to the United States," *Population Index* 58, no. 3 (Fall 1992): 381-415; U.S. Department of Labor, *The Effects of Immigration On the U.S. Economy and Labor Market*, Immigration Policy and Research, Report 1, (Washington, D.C.: U.S. Government Printing Office, 1989), pp. 179-184.

9. Michael Greenwood, testimony before the federal Commission on Immigration Reform, April 27, 1993; David S. North, testimony before the federal Commission on Immigration Reform, April 27, 1993.

10. Michael Fix and Jeffrey Passel, "Immigrants and Welfare: New Myths, New Realities" (testimony before the House Ways and Means Subcommittee on Human Resources, November 15, 1993).

11. Gregory Defreitas, testimony before the federal Commission on Immigration Reform, April 27, 1993.

12. Simon and Alexander, *The Ambivalent Welcome*, p. 40.

13. Thomas Muller, *Immigrants and the American City* (New York, NY: New York University Press, 1993), p. 165.

14. Mandel et al., "The Immigrants," p. 119.

15. "The Melting Pot," *Christian Science Monitor*, March 27, 1992.

16. Muller, *Immigrants and the American City*, p. 245.

17. Sam Fullwood III, "Children of New Arrivals Avoid Melting Into the Mainstream," *Los Angeles Times*, September 8, 1993, p. A7.

18. Fuchs, *The American Kaleidoscope*, p. 276.

19. Robert Bach, *Changing Relations: Newcomers and Established Residents in U.S. Communities* (New York, N.Y.: The Ford Foundation, 1993), p. 20.

20. Alejandro Portes and Alex Stepick, *City on the Edge: The Transformation of Miami* (Berkeley, Calif.: University of California Press, 1993).

21. Portes and Stepick, *City on the Edge*.

22. Portes and Stepick, *City on the Edge*.

23. Fullwood, "Children of New Arrivals," p. A7.

24. Muller, *Immigrants and the American City*, p. 10.

25. John Higham, "The Goals of American Immigration Policy: A Long-Term View" (testimony before the federal Commission on Immigration Reform, October 1, 1993).

26. Ngoan Le, presentation to the National Conference of State Legislatures' State-Federal Assembly Committee on Human Services at the NCSL Annual Meeting in Cincinnati, Ohio, July 28, 1992.

27. Mandel et al., "The Immigrants," p. 118.

28. Bach, *Changing Relations*, p. 20.

29. Fullwood, "Children of New Arrivals," p. A7.

30. Fuchs, *The American Kaleidoscope*, pp. 61-63.

31. Robert Bach, "Recrafting the Common Good: Immigrants and Community," *The ANNALS of the American Academy of Political and Social Science*, November 1993, p. 160.

32. Bach, *Changing Relations*, p. 48.

33. Bach, *Changing Relations*, p. 70.

34. Robert Pear, "U.S. to Encourage Legal Immigrants to Get Citizenship," *New York Times*, November 26, 1993, p. A1.

35. Deborah Sontag, "English as a Precious Language," *New York Times*, August 29, 1993, p. 29.

36. Michael Fix and Wendy Zimmermann, *Educating Immigrant Children: Chapter 1 in the Changing City* (Washington, D.C.: The Urban Institute, 1993), p. 2.

References

African Refugee Network (published by the Ethiopian Community Development Council, Inc., Arlington, Va.) 3, no. 2 (September 1993): 1.

Bach, Robert. *Changing Relations: Newcomers and Established Residents in U.S. Communities*. New York, N.Y.: The Ford Foundation, 1993.

Cose, Ellis. *A Nation of Strangers: Prejudice, Politics and the Populating of America*. New York: William Morrow & Co., 1992.

Fix, Michael, and Wendy Zimmermann. *Educating Immigrant Children*. Urban Institute Report 93-3. Washington, D.C.: The Urban Institute, 1993.

Fuchs, Lawrence H. *The American Kaleidoscope: Race, Ethnicity, and the Civic Culture*. Hanover, N.H.: University Press of New England, 1990.

"Miami a Unique Sociological Laboratory, Researchers on Immigration Find." *Chronicle of Higher Education*, September 1, 1993, pp. A7-11.

Muller, Thomas. *Immigrants and the American City*. A Twentieth Century Fund Book. New York: New York University Press, 1993.

New York City , Department of City Planning. *The Newest New Yorkers: An Analysis of Immigration Into New York City During the 1980s*. DCP #92-16. June 1992.

San Diego. City Manager's Report, 6/23/92. Report #92-210. June 1992.

Simon, Rita J. "Old Minorities, New Immigrants: Aspirations, Hopes, and Fears." *The ANNALS of the American Academy of Political and Social Science*, November 1993, pp. 61-73.

Simon, Rita J., and Susan H. Alexander. *The Ambivalent Welcome: Print Media, Public Opinion, and Immigration*. Westport, Conn.: Prager, 1993.

U.S. Commission on Civil Rights. *Civil Rights Issues Facing Asian Americans in the 1990s*. Washington, D.C., February 1992.

U.S. Department of Justice. Immigration and Naturalization Service. *Naturalization Requirements and General Information*. (Form N-17).

U.S. Department of Justice. Immigration and Naturalization Service. *Statistical Yearbook of the Immigration and Naturalization Service, 1992*. Washington, D.C.: U.S. Government Printing Office, 1993.

Waldrop, Judith. "The Newest Southerners." *American Demographics*, October 1993, pp. 38-43.

5. Federal Retrenchment, State Burden: Delivering Targeted Assistance to Immigrants

Wendy Zimmermann
The Urban Institute

The survey on which this paper is based was conducted jointly by the Urban Institute's Immigrant Policy Program and the American Public Welfare Association, as a member of the State and Local Coalition on Immigration.

Introduction

A mismatch exists between the federal government's *immigration* policy, which is inclusive and deliberate, and its *immigrant* policy, which is laissez-faire and ad hoc. Though the number of immigrants arriving in the United States is increasing, the federal dollars aimed at helping them adjust to life in the United States are decreasing. While the immigrant population is large and diverse, federal policy is generally aimed at only selected groups of newcomers.

The 1990 census counted nearly 20 million foreign-born people living in the United States. Among the 20 million are about one million refugees and 2.6 million formerly undocumented immigrants who legalized their status under the 1986 Immigration Reform and Control Act (IRCA). Although these two populations make up only a fraction of the total foreign-born population, almost all of the targeted federal money that went to states and localities during the 1980s to offset the costs of newcomers was aimed at these two groups.

These funds were provided under the Refugee Resettlement Program and State Legalization Impact Assistance Grants (SLIAG), which can be thought of as two important pieces of the patchwork of policies that make up the country's federal immigrant policy.[1] The Refugee Program provides funds to state and local governments and to voluntary agencies to resettle refugees. SLIAG reimburses states for the costs of providing certain services to immigrants who legalized their status under the Immigration Reform and Control Act of 1986 (IRCA). In addition to providing funds for cash assistance and medical and social services, they have in many cases served as an impetus to states to develop strategies for serving the larger and more diverse immigrant community.

Changes to the Refugee Program and SLIAG underscore the mismatch between immigration and immigrant policy. While the number of immigrants and refugees is increasing, Refugee Program funding is falling and the temporary SLIAG program is due to expire at the end of FY 1994. At the same time, the growing newcomer population is increasingly in need of services, with more refugees entering with little education and poor health in the late 1980s compared with those entering in the early 1980s. Shrinking federal funds, increasing immigration and immigrants' rising need for services have increased state and local governments' costs. Frustration, in part over rising immigration levels and declining federal support, is reflected in litigation brought against the federal government by Arizona, California and Florida and in a planned suit by Texas.

To document the fiscal, programmatic and institutional impact on states of policy shifts within the Refugee Program and SLIAG, the Urban Institute and the American Public Welfare Association, as part of the State and Local Coalition on Immigration, conducted a survey of Refugee Program and SLIAG coordinators.

The survey is part of an effort to help inform the larger debate about the costs and benefits of immigrants. Data on state and local costs of providing services to immigrants are largely unavailable. Where they are available, they are difficult to collect through a survey. These limitations led us to focus the survey on the effects of the Refugee Program and SLIAG, where we believed some data would be available at the state level.[2]

This chapter presents the results of the survey and addresses the following questions:

a. What state costs resulted from reduced Refugee Program funding and the implementation of SLIAG?
b. What effects did changes in these programs have on the services provided to refugees and to immigrants who legalized under IRCA?

c. What impact have these two programs, and the changes made to them, had on the states' institutional capacity to serve newcomers?
d. Finally, in light of national debate about the costs of services to immigrants and the federal role in paying for those services, what do we learn about the impacts of declining federal support for newcomers and about the way in which federal, state and local costs might be shared?

Although this chapter concentrates on the impact of two specific immigrant-targeted programs, it raises the larger question of the federal government's role in financing services for and investing in immigrants. Our results suggest that shrinking federal investment in these populations does shift some costs to states and localities. Where states and localities have not replaced lost federal funds, services have often been reduced. This analysis also indicates that declining federal dollars have reduced education and training for newcomers, which, in turn, may have restricted their employment opportunities.

In many states, the Refugee Program and SLIAG have clearly left their mark on both the public and private institutional capacity to serve immigrants and refugees. These two programs have served as an impetus for the creation of state-level offices to address the needs of newcomers in several states. Without the federal funding that has accompanied the two programs in the past, however, much of the existing state institutional capacity is threatened.

A Brief History of the Refugee Program

The Refugee Act of 1980 (P.L. 96-212; 94 Stat. 102) defines refugees as persons who have "a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group or political opinion." Because refugees are fleeing persecution and are selected without regard to potential employment or the availability of family support, the U.S. government provides financial and other support to them for a limited time after their arrival. The Refugee Resettlement Program, administered by the Office of Refugee Resettlement (ORR) in the Department of Health and Human Services (HHS), provides funds for cash and medical assistance and social services aimed at helping refugees become self-sufficient.

The story of increasing numbers of newcomers and decreasing federal support can be seen most starkly in the Refugee Program. Although the number of refugees admitted has more than doubled since the early 1980s—from 60,000 in 1983 to 122,000 in 1993—funding for the Refugee Program has been cut dramatically over the past decade. This has resulted in reduced federal spending per refugee—falling from about $7,300 in 1982 to about $2,200 in 1992, after adjusting for inflation (table 2). In FY 1994, funding for the Refugee Program went up slightly and will likely remain level for FY 1995.

Under the Refugee Program as originally designed in 1980, the federal government paid 100 percent of cash and medical assistance for refugees' first 36 months after arrival. If refugees were eligible for Aid to Families with Dependent Children (AFDC), Medicaid, or Supplemental Security Income (SSI), they received benefits under those programs, and the federal government then reimbursed states and localities for 100 percent of their share (including any state supplement to the federally funded SSI program).[3] For refugees who were not eligible because they were not single parents or families with children but who *were* financially needy by state standards, the federal government provided 36 months of special refugee cash assistance (RCA) and refugee medical assistance (RMA).[4] Since 1980, federal support for these two forms of assistance had been gradually cut back, and beginning in 1991 the federal government has provided *no* reimbursement for the nonfederal share of the categorical programs and eight months of refugee cash and medical assistance (table 3).[5]

These reductions in Refugee Program funding have had a number of effects on states and localities and on the refugees themselves. First, the reduction and eventual elimination of federal reimbursement for AFDC, Medicaid, SSI, and GA costs is a *direct cost-shift*: where previously the federal government paid 100 percent of the program costs for serving refugees, states and localities now pay the same share that they pay for other non-refugee participants in these programs, or about half of the costs. Second, the shift from 36 to eight months of refugee cash and medical assistance has also resulted in increased costs to states and localities to the extent that refugees who no longer receive RCA/RMA use *other* state or locally funded cash or medical services.

Table 2
Refugee Admissions and Refugee Resettlement Funding: 1980-1994

Fiscal year	Number of refugees admitted[a]	Refugee resettlement funding ($ millions)	Dollars per refugee[b]	Dollars per refugee (adjusted)[c]	Percent change in dollars per refugee (adjusted)	Percent change 1982 to 1992 (adjusted)
1980	207,116	$516.9	$2,496	—	—	
1981	159,252	901.6	5,661	—	—	
1982	97,355	689.7	7,084	$7,341	+17.9%	
1983	60,036	585.0	9,744	9,783	+33.3%	
1984	70,601	541.8	7,674	7,386	-24.5%	
1985	67,167	444.4	6,616	6,149	-16.7%	
1986	60,554	315.8	5,215	4,758	-22.6%	
1987	58,865	339.6	5,769	5,078	+6.7%	
1988	76,733	346.9	4,521	3,822	-24.8%	
1989	106,538	382.4	3,589	2,895	-24.3%	
1990	122,263	389.8	3,188	2,439	-15.7%	
1991	113,582	410.6	3,615	2,654	+8.8%	
1992	131,611	410.6	3,120	2,224	-16.2%	-69.7%
1993	107,887	381.5[d]	3,127	—	—	
1994	121,000[e]	400.0	3,306	—	—	

a. Includes Amerasians and their accompanying family members.
b. Dollars per refugee are based on program funds allocated and refugees admitted in that year.
c. Adjusted for inflation using the Consumer Price Index for All Urban Consumers (CPI-U), base 1982-84 = 100. This means that each dollar amount shown is expressed in terms of a weighted 1982-1983-1984 expenditure average and is therefore comparable over time. (Source: The Economic Report of the President, Table B-56, January 1993.)
d. Congress gave ORR special authority to use 1992 surplus funds for 1993, which are not included in this table.
e. Admission ceiling.

Source: Office for Refugee Resettlement (ORR), U.S. Department of Health and Human Services.

Table 3
Reductions in Refugee Cash and Medical Assistance

	Funding period		
	Categorical Programs	Special refugee cash and medical assistance	
Effective date	Reimbursement nonfederal share	RCA/RMA	General Assistance (GA) reimbursement
4/1/80	36 months	36 months	None
4/1/82	36 months	18 months	18 months
3/1/86	31 months	18 months	13 months
2/1/88	24 months	18 months	6 months
10/1/88	12 months	12 months	12 months
1/1/90	4 months (maximum)	12 months	None
1/1/91	None	12 months	None
10/1/91	None	8 months	None

Source: Joyce C. Vialet. "Refugee Admissions and Resettlement Policy." *Congressional Research Service Issue Brief*, March 3, 1992.

The size and character of the new cost burden shifted to individual states varies depending on the size of the state's refugee population, the generosity of the states' AFDC and Medicaid programs, participation in AFDC programs for unemployed parents, as well as the existence and generosity of their state and local assistance programs, such as General Assistance. Where no alternative state or local services are available, funding reductions are not borne by the public sector but by the refugees themselves.

A Brief History of SLIAG

The State Legalization Impact Assistance Grant (SLIAG) was enacted as a political compromise to offset some of the costs to states of the 2.6 million people who legalized their status under IRCA and who were barred from most services for five years. It was supposed to provide $4 billion in reimbursement, with $1 billion a year for four years, and three additional years to spend the full amount. A share of the funds, about $460 million, went to the federal government to offset some of its costs for providing certain services to eligible legalized aliens (ELAs).

SLIAG was intended to benefit state and local governments by reimbursing them for the costs of providing certain public assistance, public health and education services to ELAs. Since the legalizing population was barred from most federal assistance programs, these funds would help offset some of the increased costs to states and localities resulting from ELAs' use of state or locally funded services. SLIAG was also meant to ensure that ELAs received basic health, welfare and education services, including the 40 hours of English and civics instruction they needed in order to gain permanent resident status under the legalization program.[6] In addition, a small amount of funds could be used to provide outreach to ELAs about the steps necessary to complete legalization. Funds could also be used to educate the public about the antidiscrimination provision in IRCA that prohibits employers from discriminating against job applicants who are foreign-looking or foreign-sounding.

Unlike Refugee Program funds, SLIAG funds have not been cut, and after repeated delays and suspensions Congress has appropriated the full amount originally authorized by the Congress. Therefore, the cost-shifting issue does not apply to this program to the extent that it does to the Refugee Program. However, the administrative requirements for establishing claims and the way reimbursable costs were defined have limited the amount of reimbursement states and localities have received.

Congress recognized that the process of documenting and receiving reimbursement for costs would be a slow one for states and for that reason gave states seven years to use SLIAG funds. Nonetheless, Congress shifted $555 million of the FY 1990 appropriation into FY 1991, claiming that the slow pace at which states were drawing down their allocated funds indicated they would not need the full $4 billion. In FY 1991 Congress shifted an additional $567 million into FY 1992. Then in FY 1992 the $1.12 billion that was to become available that year was shifted again to FY 1993. In FY 1993, $812 million of the money was deferred to FY 1994. Finally, in FY 1994, despite proposals to rescind it, the last installment of the SLIAG funds was appropriated and made available to the states.

The program was designed to be temporary, intended to provide reimbursement to states for existing health and welfare services for a fixed period of time. Therefore, the money that was used to provide new educational services will soon no longer be available.

Although the SLIAG funds finally have been appropriated in full, the delays and threatened rescission of some of those funds, as well as the Refugee Program reductions, have fueled strong state complaints about federal funding for the costs of immigrants and refugees. On January 31, 1993, for example, the governors of California, Florida, New York, Texas and Illinois sent a letter to President Clinton asking for reimbursement to the states for the cost of providing services to documented and undocumented immigrants and refugees. These complaints are part of a broader national debate about the costs and benefits of immigrants. That debate, in turn, has led to numerous proposals to reduce benefits to legal and illegal immigrants and to several states' filing suit against the federal government for reimbursement for services provided to undocumented immigrants.[7] The SLIAG and Refugee Program experiences may offer insights on how the federal government should or should not provide aid to offset the impact of immigration on states and localities.

Concentration of Immigrants and Refugees

Most immigrants and refugees live in only a handful of states, which consequently bear a disproportionate part of the burden—and the benefits—of resettling them. The settlement pattern of refugees and ELAs is generally similar to that of the foreign-born population as a whole.

California receives more refugees than any other state—33,249 out of a total of 131,611 refugees who arrived in FY 1992, or one-quarter of all refugees settled in the United States that year. New York also receives a large share of all refugees—20 percent, or 26,601 in FY 1992. Illinois, Florida, Texas, and Washington each received between 5,000 and 6,000 refugees in that year, bringing the share for the top six states to about two-thirds. Another 17 states received between 1,000 and 5,000 refugees, or 30 percent of all refugees. The remaining 28 states received 8 percent in FY 1992 (table 4).

The pattern of refugee resettlement in the United States has been consistent over time. Since 1983 nearly 900,000 refugees have been resettled in the United States. About 30 percent of these refugees live in California, and about two-thirds live in six states: California, New York, Illinois, Florida, Texas, and Washington. (This distribution is adjusted for secondary migration, or the movement of refugees from the state of their initial resettlement to another state.)

This concentration is even more pronounced for the legalized population. Out of the three million applicants for legalization under IRCA, more than *half*, or 1.6 million, live in California, while only 5 percent live in New York. Eighty-four percent of ELAs live in only five states: California, New York, Texas, Illinois, and Florida. Another 12 states have more than 12,000 applicants each, making up close to 12 percent of all applicants. The remaining 33 states and the District of Columbia have only 4 percent of all applicants (table 5).

It is important to remember that states with small refugee populations also may face difficult resettlement issues. They often do not have the capacity to provide services to immigrants that some of the states with large flows of immigrants and refugees have.

Study Approach

This report draws primarily on data collected from a survey of Refugee Program and SLIAG coordinators, as well as background data collected from the federal Office of Refugee Resettlement, which administers both the Refugee Program and SLIAG. Some data were collected from localities by state coordinators.

The analysis is based on survey responses received from 40 states for the Refugee Program portion and from 33 states for the SLIAG portion. These response rates are fairly high: 78 percent of Refugee Program coordinators and 82 percent of SLIAG coordinators returned surveys (only 40 states participate in SLIAG). For purposes of analysis, the states were divided into three categories for each portion of the survey: states in which large numbers of refugees or ELAs are settled, states in which moderate numbers have settled, and states in which few have settled.[5] For the Refugee Program survey five of the six states with heavy concentrations of refugees responded (all but New York), 14 of the 17 medium concentration states, and 21 of the 28 low concentration states. Thus, states containing three-quarters of all refugees responded. For the SLIAG survey, four of the five heavy concentration states responded, 11 of the 12 medium concentration states, and 18 of 34 low concentration states. Thus, states containing 93 percent of all ELAs responded to the survey.

The surveys sent to the state coordinators were designed to collect both quantitative and qualitative information about the Refugee Program and SLIAG. One purpose of the surveys was to document the costs to states resulting from changes made to the Refugee Program and any nonreimbursed costs to states for serving the legalized population. A second purpose was to document the institutional changes associated with the programs' operation and the decline in support. The survey was also intended to document the impact of the programs on the offices that administered them and on the states' capacities to provide services to newcomers.

Table 4
Refugee Arrivals by State: FY 1992
(Total number of refugees = 131,611)

States with a high concentration of refugees (>5,000; n=6)		States with a medium concentration of refugees (>1,000; n=17)		States with a low concentration of refugees (<1,000; n=28)	
State	# of refugees	State	# of refugees	State	# of refugees
California	33,249	Pennsylvania	4,222	North Carolina	887
New York	*26,601*	Massachusetts	4,185	Louisiana	811
Texas	5,918	Maryland	3,142	*Iowa*	*808*
Washington	5,421	Georgia	3,124	Nebraska	791
Florida	5,321	New Jersey	2,896	Kansas	700
Illinois	5,083	Minnesota	2,754	Kentucky	640
		Michigan	*2,682*	Utah	565
		Oregon	*2,496*	*North Dakota*	*477*
		Ohio	*2,330*	Rhode Island	448
		Missouri	2,065	New Mexico	389
		Virginia	1,987	Oklahoma	354
		Wisconsin	1,874	*Indiana*	*350*
		Arizona	1,520	Hawaii	336
		Tennessee	1,309	Alabama	311
		Connecticut	1,217	Nevada	305
		Colorado	1,135	Idaho	305
		Dist. of Columbia	1,110	South Dakota	278
				Vermont	263
				New Hampshire	213
				Maine	157
				South Carolina	144
				Montana	88
				Alaska	81
				Arkansas	71
				Delaware	*64*
				West Virginia	*46*
				Mississippi	*44*
				Wyoming	*11*
Total	81,593 62%	Total	40,038 30%	Total	9,937 8%

Note: Those states in italics did not return the Refugee Program Survey and are therefore not included in the analysis in the text. Classification based on refugee and Amerasian arrivals in FY 1992. The total number of refugees listed by state does not add to 131,611 because 43 refugees went to U.S. territories or the state they arrived in was unknown.

Source: Office of Refugee Resettlement, U.S. Department of Health and Human Services, *Annual Report FY 1992*, p. A-4.

Limitations of Data

This study suffers from a limitation common to many studies assessing the fiscal impact of immigrants: the limited availability of data on the costs of providing services to newcomers. Many states do not separately track refugees participating in their public welfare programs; therefore, they cannot provide data to fully assess the fiscal impacts of cutbacks in the Refugee Program. Costs incurred by states and localities but not reimbursed under SLIAG were often not reimbursed *because* ELAs were not tracked in certain services. In fact, several states reported that where ELA participation was low, it was too costly to document the use of those services by ELAs. Further, there is considerable variation in how states document the services used by immigrants and refugees. For example, states document costs for different periods of time; some track the number of times a service is used, others the number of people using a service.

Table 5
Legalization Applicants by State: FY 1992
(Total number of applicants = 3,040,948)

States with a high concentration (>150,000; n=5)		States with a medium concentration (>12,000; n=12)		States with a low concentration (<12,000; n=34)	
State	# of ELAs	State	# of ELAs	State	# of ELAs
California	1,622,051	Arizona	82,898	Oklahoma	11,068
Texas	449,197	New Jersey	45,983	Idaho	10,116
New York	*174,189*	Washington	37,924	Pennsylvania	9,306
Illinois	160,419	New Mexico	28,223	Kansas	7,936
Florida	151,632	Oregon	27,463	Utah	7,447
		Georgia	24,322	Michigan	6,879
		Colorado	22,849	Connecticut	6,355
		Nevada	*20,454*	Dist. of Columbia	6,034
		Virginia	19,434	*Wisconsin*	*4,336*
		Massachusetts	18,311	Nebraska	3,678
		North Carolina	16,989	Indiana	3,588
		Maryland	12,536	South Carolina	3,327
				Louisiana	3,019
				Rhode Island	2,960
				Ohio	*2,872*
				Arkansas	2,780
				Iowa	*2,560*
				Tennessee	2,436
				Hawaii	2,393
				Missouri	*2,224*
				Minnesota	2,175
				*Alabama**	*1,805*
				*Delaware**	*1,312*
				Wyoming	*1,072*
				*Alaska**	*781*
				*Kentucky**	*750*
				*Mississippi**	*713*
				New Hampshire	613
				*West Virginia**	*404*
				*Maine**	*288*
				*Montana**	*234*
				*South Dakota**	*125*
				*Vermont**	*64*
				*North Dakota**	*66*
Total	**2,577,488**	**Total**	**357,386**	**Total**	**111,716**
	84%		**12%**		**4%**

Note: Those states in italics did not return the survey and are therefore not included in the analysis in the text. Those states with an asterisk do not participate in SLIAG, usually because the state found it cost-ineffective to apply for reimbursement. Legalization applicants include those applying because they had been in the country for at least five years (I-687) and those applying under the special agricultural worker (I-700) SAW provision.

Source: Provisional Legalization Application Statistics, Statistics Division, Office of Plans and Analysis, U.S. Immigration and Naturalization Service, August 15, 1992.

For these reasons, this report does not try to estimate total immigrant and refugee costs for all state and local governments.[7] Rather, it provides data for selected states on the costs of providing certain services to refugees and ELAs.

This limitation points to the need for better and more systematic documentation of the use of services by refugees and immigrants in order to assess their costs and benefits more completely in the future.

State Costs

More than half the states responding to the Refugee Program survey were unable to provide cost data, primarily because they did not track refugees in the welfare system once the states were no longer receiving reimbursement for the refugees' costs. Nineteen states reported specific costs for FY 1991 for refugees in the country 36 months or less. Those costs represent annual state outlays that would not have been made if the federal government had continued to reimburse state and local governments for the costs of providing AFDC, Medicaid, SSI and General Assistance for 36 months as it did in 1980. They reflect, then, the state and local costs associated with the federal government's retreat from its original funding commitment.

State costs vary significantly for a number of reasons. These include differences in benefit program structures, payment levels, welfare usage and capacity to track or estimate costs.[10] Although all states are required to have in place AFDC programs for unemployed parents (AFDC-UP) under which poor, two-parent families can receive benefits, some states, including Florida and Texas, have a limit on the time period during which families can receive benefits. Further, payment levels vary significantly. California's AFDC program for unemployed parents paid an average of $733 per family in FY 1992, compared with $382 in Florida and $205 in Texas.[11] Additionally, some states have a General Assistance program while others do not, and the payment levels for that program may also vary greatly. These variations in a state's benefit structure and payment levels, therefore, have a significant effect on the level of cost-shifting to the states (table 6). Those states with time limits on the duration of AFDC-UP benefits, with low payment levels and with no General Assistance program are therefore likely to incur much lower cost-shifts than states with a generous benefit program structure.

Further, there is wide variation in refugees' welfare participation rates. Census data indicate that in 1990 about 17 percent of recent arrivals from countries sending large numbers of refugees received public assistance. The equivalent share for California was 27 percent and for Texas 10 percent. New York, which did not respond to the survey, has a participation rate equal to the national rate: 17 percent.[12]

It is not entirely surprising, then, that California reported much higher costs than any other state—an estimated $81 million in state and local **AFDC** costs for FY 1994. California's high costs are due to the state's large number of refugees, its high payment levels, and its relatively high refugee welfare use rates. The state of Washington reported $4.21 million in AFDC costs for FY 1991, far higher than any other state except California. Total reported AFDC costs are $87.5 million.

Fifteen states, including Washington, Illinois and Florida, reported state and local **Medicaid** costs of $9.8 million, $3.6 million of it from Washington. Only seven states were able to report costs incurred under the **SSI** state supplement. They totaled $822,355, with only one large state, Illinois, reporting costs for that program. Finally, six states, including Washington and Illinois, reported incurring $9.6 million in cost-shifts under **General Assistance** (table 7).

Florida reported comparatively low refugee costs of $584,607 under AFDC and Medicaid. These low costs probably are a result of its lower payment rates and its lack of a state-wide General Assistance program. Florida is currently suing the federal government for reimbursement for the costs of providing services to undocumented immigrants, refugees and legal immigrants.

These cost-shifts for AFDC, Medicaid, SSI, and General Assistance, total $107.7 million for one fiscal year, but only $26.7 million when California is not included. This table should *not* be taken as an estimate of total cost-shifts to all states resulting from reduced Refugee Program funding since these are annual estimated costs for only 19 states and some programs. The costs incurred by New York, the state that receives the second largest number of refugees, are not included here.

When viewed over the long-term, these cost-shifts are significant. Assuming that over the next five years the number and type of refugees stay about the same, these costs could add up to at least $500 million—a significant amount of money for this limited number of states and programs.

Washington, for example, could incur close to $50 million in costs over five years. If an increasing share of refugees have little education and greater health care needs, the costs could be higher. They

Table 6
Benefit Structures and Payment Levels of Selected States: FY 1992

State	AFDC-UP[1] time-limited eligibility	Average AFDC-UP payment level per family	General Assistance	General Assistance payment level
California	No	$733	Yes	$510
Texas[2]	Yes	$205	No	—
Florida[3]	Yes	$382	No	—
Washington	No	$557	Yes	$531
Illinois	No	$394	Yes	$367

1. The term AFDC-UP is an acronym for Aid to Families with Dependent Children/Unemployed Parents. Time-limited eligibility means that families are eligible for benefits for only a fixed period of time.
2. Selected counties in Texas have emergency programs to assist the poor or disabled.
3. Florida has no statewide General Assistance program; Dade County has a program under which disabled persons are entitled to benefits for a maximum of six consecutive months.

Sources: U. S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs, 1993 Green Book*, July 7, 1993; Marion Nichols, Jon Dunlap, Scott Barkan, *National General Assistance Survey, 1992*.

may, however, be offset by a possible decline in the number of refugee admissions. Further, though the survey collected data on only one year's costs, states have been incurring direct cost-shifts each year since 1982 when the federal government began to shorten the reimbursement period.

The survey results appear to be in line with a 1990 analysis by the Oregon refugee coordinator who estimated the cost-shifts to states resulting from the federal reduction in the reimbursement period from 24 to four months. That analysis estimated that in FY 1990 all states would absorb $85 million in costs as a result of that reduction. Despite the incompleteness of the survey data used here, cost estimates are higher probably because the reimbursement period has since been eliminated and because the survey sought to estimate costs for refugees here fewer than 36 months, not 24. Service costs have also increased somewhat since the Oregon study was conducted.[13]

Cost-shifting under SLIAG has taken a different twist. Despite deferrals in the appropriations, the grants have been fully funded. But the way in which states have been allocated funds under SLIAG will leave some states with shortages at the end of the program in FY 1994 and others with surpluses. The formula for distributing SLIAG funds was based partly on the number of ELAs and partly on the costs of services in each state. Nonetheless, the actual costs of services in several states, including California, were higher than anticipated. Those high-cost states spent more on their ELAs than they were allocated funds under the formula.

Congress has responded by allowing a one-time redistribution of "leftover" SLIAG dollars to those states with approved costs that exceed their total allocation.[14] HHS expects the amount distributed to be about $311 million.[15] California, with an HHS-projected shortage of about $201 million, will benefit most from this reallocation. New York, Minnesota, Washington, Rhode Island and Washington, D.C. are also expected to have shortages and to receive funds. After the reimbursement is complete, HHS expects there to be about $75 million unspent.[16] Some state officials, however, argue that there will be no SLIAG funds left over after the redistribution.

The real surprise in SLIAG, however, is that there may be leftover funds at all. In a GAO study conducted in 1991, states estimated that $4.2 billion would be needed to cover their costs, *more* than the $4 billion allocated under SLIAG.[17] Part of the reason for the leftover funds lies in how the program was defined and implemented. These implementation choices, in turn, reveal that there were in fact some state costs that might have been reimbursed but were not. Delays in getting regulations written, spending deferrals and the way allowable costs had to be documented led some states to *not* seek or receive reimbursement for certain services. A number of states with small ELA

Table 7
State Reported Uncompensated Refugee Costs by Program: FY 1991

State/State Group	Total reported costs	AFDC	Medicaid	SSI	GA
TOTAL ALL STATES	**$107,700,924**	**$87,494,340**	**$9,775,940**	**$822,355**	**$9,608,289**
Total 4 Large States	94,200,507	86,079,939	4,862,568	54,000	3,204,000
California[a]	81,000,000	81,000,000			
Washington*	8,881,900	4,212,900	3,565,000		1,104,000
Illinois*	3,734,000	700,000	880,000	54,000	2,100,000
Florida	584,607	167,039	417,568		
Total 6 Medium States	12,831,317	1,089,168	4,806,149	751,000	6,185,000
Pennsylvania*	6,870,000	325,000	500,000	45,000	6,000,000
Colorado*	2,985,000	350,000	1,850,000	600,000	185,000
New Jersey#	2,109,863	195,315	1,914,548		
Massachusetts#	546,454	108,853	391,601	46,000	
Arizona*	270,000	60,000	150,000	60,000	
Tenessee*	50,000	50,000			
Total 9 Small States	669,100	325,233	107,223	17,355	219,289
Hawaii	445,879	210,966		15,624	219,289
Nebraska	100,958	55,149	44,078	1,731	
North Carolina	58,978	14,630	44,348		
South Carolina*	25,194	9,639	15,555		
Nevada[b]	16,202	16,202			
New Hampshire#	7,478	6,294	1,184		
Alabama	5,082	5,082			
Idaho[c]	5,070	3,012	2,058		
Louisiana	4,259	4,259	0		

Note: Actual or estimated state and local costs for providing services to refugees who have been in the country for 36 months or less as reported by states in the Urban Institute/APWA Survey.

a. California's AFDC table is an estimate of its costs for FY 1994.

b. Nevada's costs are for FY 1992.

c. Idaho provided costs for refugees here less than 24 months.

*These states provided estimated costs. Washington's Medicaid costs are estimated; its AFDC and GA costs are actual costs.

#These states provided costs for refugees here less than four, not 36, months.

populations chose not to participate in SLIAG because of the cost documentation requirements.

Only four states reported that they had submitted costs for reimbursement that had been rejected by HHS. These states, Massachusetts, New Jersey, Louisiana and Pennsylvania, reported that they had a total of $1.2 million in costs that were rejected—a fraction of the $3.2 billion that had been approved under SLIAG as of December 1993.[18]

Although few states reported rejected costs, many claimed that reimbursable costs had been defined too narrowly early on. They also reported that HHS often did not approve their proposed methodologies for calculating costs. States complained that there were disincentives to submitting costs that might be rejected because applications had to be accepted in their entirety and disputed costs would hold up all reimbursement. Funding deferrals resulted in lower annual allocations for states, leading some (California, for example) to budget and spend less money on adult education than they would have had the funds not been deferred.

In addition to these barriers, states reported that there were allowable costs that simply could not be documented. In some cases, the providers did not

know about the availability of SLIAG funds; in others, the administrative costs of documenting ELAs' use of services were greater than the amount that would have been reimbursed.

States also incurred costs for providing services to ELAs that were *not* reimbursable under SLIAG. Texas, Florida, Massachusetts, Pennsylvania, Arizona, and Colorado reported a total of $24.45 million in services for ELAs such as day care, food, shelter or child protective services that were not covered under SLIAG. Because of incomplete reporting, this is plainly a lower-bound estimate of the additional costs of serving ELAs.

Growing Needs and Reduced Services

The impact of reduced federal spending has been felt not only by state and local governments but by the refugees themselves. As previously mentioned, refugees who are not eligible for AFDC and Medicaid may receive refugee cash and medical assistance. Federal support for this refugee assistance was cut from 36 months in 1980 to eight months in 1991. When the eight months are over, eligible refugees can usually get state or locally funded General Assistance or General Relief. However, where no such program exists, refugees are left without assistance.

Reductions in Public Assistance

Although 42 states have some type of General Assistance program, many are administered on a county (versus state) level, so benefits vary from locality to locality in terms of eligibility criteria, amount and duration of benefits.[19] California's statewide program offers a maximum monthly benefit of $510 for a three-person family living in Los Angeles. Nearly all needy people who do not qualify for federally funded cash assistance programs are eligible. Texas, on the other hand, does not have a statewide program, but some counties operate their own assistance programs. In Harris County, Texas, only the disabled and unemployed parents with children are eligible for benefits which run to a maximum of $198 for a family of three. Dade County, Fla., provides emergency assistance to disabled people for a maximum of six months (see table 6).[20] Given this type of program variation, in some ways it is not surprising that refugee participation in public assistance programs, and hence refugee costs, would be high in California. The survey provided interesting anecdotal evidence of developments within local refugee populations that may, at least in part, be tied to the reduced availability of public assistance to refugees. Both Texas and Virginia reported that teenagers dropped out of school to help support their families, and Texas reported increased crime among its refugee youth.

Some states may have public assistance programs for which refugees are eligible, but services may not be adapted to meet their linguistic and cultural needs. Idaho, for example, reported that although the state administers safety net programs, they are not accessible to refugees.

Reductions in Language and Job Training

Not only did federal cash and medical assistance funding per refugee fall by 74 percent between 1984 and 1992, social service spending fell by 60 percent (after accounting for inflation) from $950 to $509 (table 8).[21] Social service funds are used to orient refugees to life in the United States and for language and job training. As the period of cash and medical assistance has decreased and refugees have been pushed into early employment, some states have had to forgo offering language and job training in order to pay for job placement services. Others have had to reduce the types of services provided. The Kansas coordinator, for example, reported that employment training and ESL are provided at the expense of social adjustment and non-employment-related services.

As social service funds declined, refugees' need for services was rising. Many refugees arriving in the late 1980s had less education than those who arrived earlier. For example, 33 percent of refugees arriving between 1980 and 1984 had fewer than eight years of education compared with 40 percent of those arriving between 1987 and 1990. Additionally, the share of refugees who were limited English proficient (LEP) also rose during the decade. Sixty-five percent of those arriving in the early 1980s were LEP compared with 77 percent of those arriving in the late 1980s.[22]

The survey revealed that of all social services, states were most likely to reduce English language training. Eighteen out of 40 states (four with large numbers, six with moderate numbers, and eight with low numbers) reported either reducing the number of sites for or hours of language training, reducing the duration of services or eliminating

Table 8
Refugee Program Funding by Type of Service: FY 1984 and FY 1992

Type of Service	1984 (70,601 refugees)			1992 (131,611 refugees)			Percent change in dollars per refugee (Adjusted)
	Total funding /1,000	Dollars per refugee[a]	Dollars per refugee (Adjusted)	Total funding (/1000)	Dollars per refugee	Dollars per refugee (Adjusted)	
All services	**$341,897**[b]	**$7,675**	**$7,387**	**$410,630**	**$3,120**	**$2,224**	**-69.9%**
Cash and medical assistance	357,127	5,058	4,869	232,477	1,766	1,259	-74.1%
Social services	66,972	949	913	67,009	509	363	-60.3%
Preventive health	8,400	119	115	5,631	43	30	-73.4%
VOLAG matching grant program	4,000	57	55	39,036	297	211	287.7%
Targeted assistance	37,530	532	512	48,796[c]	371	264	-48.3%
Demonstration/special projects, discretionary social service allocations	2,213	31	30	12,476	95	68	124.0%
MAA grant program	3,279	46	45	3,467	26	19	-58.0%
Other[d]	22,412	317	306	1,739	13	9	-96.9%

Note: Adjusted for inflation using the Consumer Price Index for All Urban Consumers (CPI-U), base 1982-84=100. This means that each dollar amount shown is expressed in terms of a weighted 1982-1983-1984 expenditure average and is therefore comparable over time. (Source: The Economic Report of the President, Table B-56, January, 1993.)

a. Dollars per refugee are based on program funds allocated and refugees admitted in that year.
b. Includes $39,964,000 in targeted assistance funds available from the previous fiscal year.
c. Includes $4,880,000 provided as targeted assistance under discretionary allocations as well as $43,916 provided under state formula allocation.
d. Programs such as Education Assistance for Children, Federal Administration, demonstration/special projects, privately administered and Wilson/Fish projects.

Source: Office for Refugee Resettlement, U.S. Department of Health and Human Services, *Annual Report to Congress*, FY 1984 and FY 1992.

language instruction altogether. Four of the five states with large numbers of refugees—California, Florida, Illinois and Texas—reduced the language services provided to refugees. In fact, the only social services that California reduced were language services. Eight states, including Illinois and Texas, reported eliminating language instruction to refugees.

These reductions in language services have come at a time when many states, particularly those with large numbers of immigrants and refugees, have large and growing populations with limited English proficiency. For example, 4.5 million, or 15 percent, of California's population are LEP, and 1.7 million people, or 10.4 percent of the population, in Texas are LEP (table 9).

Table 9
Limited English Proficiency (LEP) and Foreign-born Populations by State: 1990

State	Total Population	LEP population		Foreign-born population	
		Number	% Total	Number	% Total
All states	**248,124,018**	**13,979,192**	**5.6%**	**19,724,04**	**2.9%**
California	29,690,843	4,468,568	15.1	6,463,106	21.8
New York	17,902,276	1,773,268	9.9	2,850,288	15.9
Texas	16,869,020	1,749,944	10.4	1,511,090	9.0
Florida	12,930,156	955,164	7.4	1,661,640	12.9
Illinois	11,175,750	663,375	5.9	944,505	8.5
New Jersey	7,578,909	597,506	7.9	975,247	12.9
Massachusetts	6,009,744	332,449	5.5	566,878	9.4
Pennsylvania	11,781,666	296,550	2.5	380,844	3.2
Arizona	3,644,173	258,700	7.1	270,608	7.4
Ohio	10,393,488	192,944	1.9	253,824	2.4
Michigan	9,275,382	192,242	2.1	352,146	3.8
Connecticut	3,278,282	187,810	5.7	280,630	8.6
Washington	4,878,405	168,120	3.4	326,250	6.7
New Mexico	1,500,360	163,620	10.9	85,635	5.9
Virginia	6,086,985	155,700	2.6	310,365	5.1
Maryland	4,580,100	142,590	3.1	309,120	6.7
Hawaii	1,106,126	122,794	11.1	156,100	14.1
Louisiana	4,186,905	114,540	2.7	81,405	1.9
Colorado	3,295,935	111,900	3.4	142,335	4.3
Georgia	6,289,738	105,448	1.7	166,194	2.6
Wisconsin	4,791,360	89,064	1.9	116,424	2.4
Oregon	2,836,864	84,672	3.0	141,888	5.0
North Carolina	6,605,970	84,630	1.3	114,675	1.7
Indiana	5,429,520	80,928	1.5	82,336	1.5
Minnesota	4,047,816	76,498	1.9	107,939	2.7
Nevada	1,192,230	62,712	5.3	102,713	8.6
Rhode Island	994,838	59,033	5.9	85,111	8.6
Oklahoma	3,117,681	58,786	1.9	66,725	2.1
Missouri	5,125,177	53,737	1.0	77,248	1.5
Kansas	2,455,974	50,418	2.1	61,596	2.5
Utah	1,716,762	45,492	2.6	61,370	3.6
Tennessee	4,677,690	39,345	0.8	54,390	1.2
South Carolina	3,488,295	37,875	1.1	51,450	1.5
Iowa	2,453,094	35,448	1.4	39,081	1.6
Alabama	3,975,536	32,368	0.8	45,696	1.1
Kentucky	3,462,858	27,288	0.8	29,232	0.8
Maine	1,127,896	25,630	2.3	31,438	2.8
Dist. of Columbia	597,744	25,584	4.3	52,848	8.8
Mississippi	2,511,435	25,110	1.0	21,585	0.9
Alaska	544,141	25,080	4.6	28,234	5.2
New Hampshire	951,592	24,514	2.6	39,559	4.2
Nebraska	1,535,793	21,483	1.4	26,061	1.7
Idaho	1,002,820	20,740	2.1	28,660	2.9
Arkansas	2,123,676	20,538	1.0	21,456	1.0
West Virginia	1,397,718	13,230	0.9	14,652	1.0
South Dakota	695,640	11,304	1.6	7,992	1.1
Montana	783,541	10,412	1.3	13,661	1.7
Wyoming	459,216	8,838	1.9	6,534	1.4
North Dakota	536,850	7,925	1.5	7,275	1.4
Vermont	557,986	6,578	1.2	14,118	2.5
Delaware	226,832	4,656	2.1	3,696	1.6
Unidentifiable	4,245,230	56,044	1.3	77,189	1.8

Note: Limited English Proficiency is defined here as those people who speak a language other than English at home and who report their English language speaking ability as less than "very well."

Source: Census of Population and Housing, 1990: Public Use Microdata 1 Sample, U.S., Bureau of the Census, 1992.

Reducing language services to newcomers can have a significant effect on their earnings and employment. Research has found that foreign-born workers who are fluent in English have earnings that are 17 percent higher than comparable workers.[23] In addition, the Office of Refugee Resettlement's annual survey of refugees found that those refugees who reported that they were fluent in English were more likely to be working than those who said they spoke English a little or not at all. Fifty-two percent of refugees speaking English fluently were participating in the labor force, versus 37 percent who spoke a little English and 8 percent who did not speak English at all.[24]

Refugees who lost language services provided through the Refugee Program may receive English as a Second Language (ESL) training through a state's adult education system, which in some places is already strained by large LEP populations. As Illinois' refugee coordinator put it, "ESL and skills training are now dependent on available slots in mainstream programs." Although data on availability of ESL are scarce, existing evidence indicates that in places where newcomers are concentrated, including Los Angeles and New York City, waiting lists are often long.[25] At least three states, Virginia, Massachusetts and Utah, that reported reducing their language training, did report waiting lists for ESL services in those states. Virginia reported, for example, that Arlington and Fairfax County both had waiting lists; in Fairfax County 732 people were on the list, a significant number since the state provided ESL to 4,600 people in 1991.[26] Massachusetts reported waiting lists as long as two or three years.[27]

Texas, however, reported that ESL was available statewide through local school districts' Adult Education Programs; therefore the refugee program's language service was deleted without eliminating its availability. Where refugees are able to get into state-run ESL classes, those classes are usually funded by a combination of federal and state dollars. On a national level, states spend about four dollars for every dollar spent by the federal government. Some states spend more. California, for example, spends seven dollars for every federal dollar spent.[28] It can be argued that the reduced federal support for social services, which pushes refugees from largely federally funded programs to mostly state-funded language programs, is a form of cost-shift.

Twice as many states reduced language training than reduced job training or placement services—10 states reported making some reduction in job training and nine states reduced job placement services (compared with 18 that reduced language training). Of the states with large numbers of refugees, Illinois reduced both job placement and training, and Texas reduced only job training. States may have reduced language services more often than job services because of the Refugee Program's emphasis on getting refugees employed quickly. This focus on rapid employment can also be seen in staffing patterns. Illinois reported increasing its staffing for employment services to refugees in the United States fewer than 12 months and decreasing staffing for employment services for its longer-term, presumably more difficult to employ, refugees.

Reduced employment services have also made it more difficult to get refugees into good jobs. California, Maine and Massachusetts reported that the limited availability of social services meant that they have more refugees with poor English and job skills who find it difficult to compete for jobs. Refugees often must take jobs with few or no benefits, low wages and little opportunity for mobility. With less job training support available, some refugees may remain on state or locally funded public assistance, imposing higher welfare costs. The California refugee coordinator reported, "Declining federal funding for English, vocational training, employment and other services means that many refugees will continue to go unserved. In some counties no services can be provided at all. Poor English, job skills and education levels do not allow them to compete effectively for jobs. Therefore, it is anticipated that refugees will stay on AFDC longer." It is difficult, however, to disentangle these effects from the effects of an economy that has gotten worse and from the fact that more refugees have arrived with lower human capital.

Reductions in Health Services

More refugees are entering with health problems in the late 1980s and early 1990s than in earlier years, but fewer resources are available to provide them with medical care. The number, and share, of refugees from the former Soviet Union has grown from less than 1,000 in 1984 (1 percent of all refugees) to more than 60,000 (46 percent) in 1992.[29]

Many of the Soviet refugees are older and often less healthy than other refugees. Many are also accustomed to frequent use of health care, which also drives up costs.[9] These trends are occurring while Refugee Program funds for preventive health services are declining. These funds dropped by 73 percent (after inflation) between 1984 and 1992, from $119 to $43 per refugee, about the same rate at which cash and medical assistance funding dropped.

As funding for preventive health services has declined, some states have had to cut basic health services to refugees. Texas, Montana, Oklahoma, and Utah reduced immunizations to refugees, posing a risk not only to refugees but also to the public. California expanded its immunizations but restricted initial health screenings (health assessments conducted after arrival), follow-up after the health screening and other health services.

Seven other states, including Texas and Washington, also limited their health screenings to refugees. And 12 other low and medium concentration states reduced the extent to which they provided follow-up health care.

Some states reported that limited refugee medical assistance has also resulted in increased use of emergency services. Virginia's refugee coordinator stated, "More refugees are arriving with health problems and after refugee medical assistance expires, refugees often use emergency room facilities for all medical care or do not get care." Texas reported that there has been "increased use [of emergency services] due to a lack of health insurance in entry-level jobs." Since emergency medical services are generally more expensive to deliver than preventive services or those delivered in a doctor's office, this too has resulted in increased costs.

Although state respondents were not able to track the costs of providing emergency services to refugees, cost-shifts occur here, too. Federal anti-dumping laws require hospitals to provide people with emergencies with necessary stabilizing treatment.[11] If costs are not paid for by Medicaid or Refugee Medical Assistance and the refugees themselves are not able to pay for the services, then hospitals pass on uncompensated costs to other private and public payers, including federal, state and local governments. Thus, to the extent that reduced refugee services have led to increased use of emergency services, this has also resulted indirectly in a cost-shift to state and local governments.

Reduced funds have also resulted in cuts in bilingual health care staff and in mental health services. Georgia reported having to cut 25 percent of its bilingual staff since 1988. Illinois reported cutting its mental health care staff in half, and Texas and Georgia also reduced mental health services to refugees.

Maintaining and Expanding Social Services

While reduced federal support led to fewer services in most states, a few states maintained or expanded services despite decreased social service funding. In some cases other federal, state or local sources of funding were found to provide the services, which can be viewed as another form of cost-shifting. In a few cases, states developed innovative approaches to delivering services more cost-effectively.

Although 18 states reduced language services to refugees, 14 states expanded language training, and 13 states expanded job training and placement services. However, 13 out of the 14 states that expanded services did not have large numbers of refugees; hence, the funding required was not great. Washington was the only state with a large number of refugees that expanded language services. Florida and Washington expanded job training and job placement services, while Texas expanded only placement services.

Expanded language and skills training may be tied to reduced cash and medical assistance. The refugee coordinator from Rhode Island reported that the state found it necessary to expand ESL, Vocational ESL and job placement services *because* the time available for finding refugees employment was limited.

Several states maintained or expanded services simply because they received increased Refugee Program funding. Maryland, for example, reported that its Refugee Program social service funding rose in proportion to its increasing number of refugees. Alabama, Colorado and Kentucky reported replacing declining social service funds with other HHS discretionary funds for refugees, such as Job Links or Targeted Assistance.[12]

Other states replaced declining Refugee Program funds with other federal or state funds. Maine

reported that refugees participated in a prevocational education program funded by a federal Carl D. Perkins grant. In Hawaii and New Mexico state dollars were provided for services. Hawaii reported finding ways to deliver ESL services more cost-effectively. New Jersey and Nevada reported improved coordination between mainstream and Refugee Program service providers as refugee and adult education ESL were combined.

Education provided under SLIAG also represented an expansion in services. A large portion of SLIAG funds was used to provide the required English and civics instruction that the legalizing population needed to adjust from temporary to permanent resident status. These funds could be used not just to meet the skeletal 40 hours of instruction that was mandated, but for additional language instruction as well. In many states these funds allowed for an expansion in language services. However, it was available to only a specific immigrant subpopulation, that is, ELAs. Overall, about $665 million, or about 21 percent of all SLIAG funds spent, have gone toward education, primarily English as a Second Language (ESL).

SLIAG spending for this and other purposes, however, was designed to be temporary and when it ends there will be a contraction in services. In fact, SLIAG funds dedicated to education have been declining in the later years of the program (table 10). In FY 1989 nearly $222 million, or 36 percent of all SLIAG funds awarded in that year, were spent on adult education. In FY 1992 that amount decreased to only $75 million, or 11 percent of SLIAG funds. California, for example, will no longer receive the nearly $50 million in SLIAG monies for adult education that it received in FY 1992.

At the same time, SLIAG-funded education services provided to the large legalizing population appear to have induced a greater demand for language and other training within this population. Sixteen states—including Texas, Florida and Illinois—reported sustained demand for ESL beyond the 40-hour requirement. Though SLIAG stimulated increased institutional capacity to provide language services, funding to support it has largely disappeared. Demand for language training, however, has not disappeared and is likely to further strain state and locally funded English language classes.

The Legacy of the Refugee Program and SLIAG

Our respondents generally agreed that the Refugee and SLIAG programs have created substantial new institutional capacity to serve immigrants and refugees at the state and local level. Though SLIAG was primarily a reimbursement program, the state offices that administered the grants and the expansion in education services had the unintended effect of helping to create institutional capacity to serve immigrants at the state level. In fact, 17 states reported that at least some of the institutional

Table 10
SLIAG Costs by Program: FY 1987-1993
($ millions)

Year	Public assistance	Public health assistance	Education K-12	Adult education	Anti-discrimination	Outreach	SLIAG administration	Total
All years	**$2,147.3**	**$270.9**	**$5.9**	**$662.5**	**$5.6**	**$7.0**	**$79.3**	**$3,178.4**
1987	0.0	5.3	0.0	0.0	0.0	0.0	.3	5.6
1988	171.1	32.0	2.2	26.0	0.0	0.0	6.4	237.8
1989	320.1	52.5	2.5	222.0	0.0	0.4	13.1	610.6
1990	416.0	56.2	0.9	195.8	0.3	1.3	18.0	688.6
1991	509.1	60.3	0.3	131.9	1.7	3.9	19.8	726.9
1992	528.6	55.1	0.0	74.7	2.3	1.3	17.1	679.1
1993*	202.3	9.5	0.0	12.1	1.3	0.1	4.6	229.8

*First half of year only
Source: Division of State Legalization Assistance, U.S. Department of Health and Human Services

capacity to serve immigrants established with SLIAG support is likely to remain in place. This expanded capacity includes more teachers and organizations able to deliver language and job training services, new training curricula and materials and individuals in state bureaucracies committed to serving newcomers.

Although SLIAG funding for education services is due to expire, a proposal was introduced in Congress in the fall of 1993 (H.R. 3495 and S.1407) to use possible surplus SLIAG funds for educational services (i.e. ESL) and for outreach regarding naturalization and citizenship. These are the funds that may remain *after* the initial surplus has been redistributed to reimburse states for costs that were not covered in their original allocation. The bill provides $61 million for states based on their number of ELAs. Services would be provided only to the legalized population that would remain eligible until FY 1997. This extension would also turn SLIAG into a *ten year* program. Although the first priority for SLIAG funds should be full reimbursement of service costs, this proposal would ensure that *if* funds are left over, they would go toward helping to maintain, at least for a short while, some of the capacity to provide services that was created under SLIAG.

Beyond the field of education, the Refugee Program and SLIAG have helped in other ways to create state and local institutional capacity to serve newcomers. First, and perhaps most important, several states have turned their Refugee and SLIAG administrative programs into state-level offices aimed at addressing the needs of newcomers more generally. These include Massachusetts, Texas, Maryland and Virginia. Other states, though not creating state-level offices, broadened the scope of their activities to better address the needs of the entire immigrant population. New Jersey, Nevada, North Carolina, and South Carolina used these programs to coordinate with mainstream service providers and make them more accessible to refugees and immigrants. Idaho provides an interesting example of how these two programs helped raise awareness of other immigrant issues at the state level. It reported that it planned to use state funds to start an Immigrant Family Counseling Program.

Second, the Refugee Program helped create and support community based organizations, such as mutual assistance associations that provided refugees with employment related services and helped them to integrate into the community. Many of these private organizations have then used other sources of funds to serve the immigrant population more broadly. Finally, through SLIAG and the Refugee Program, networks of service providers have been created, and those providers have learned more about the demands of the newcomer population.

The loss of staff members who have acted as advocates for immigrants and refugees, however, is likely to affect states' ability to broadly serve immigrants. This is especially true in states with smaller immigrant populations where there are fewer state and local officials paying attention to their specific needs. With regard to language services, South Carolina's SLIAG coordinator reported, "We expect that the lack of an advocate for constant evaluation of the need for adult education services to non-English speakers will cause a reduction in services." When asked about the combined effect of reductions in Refugee Program funding and termination of SLIAG, the Texas coordinator reported, "The state may move into a more passive, reactive mode, rather than addressing programs and policy affecting the immigrant/refugee population and the state in a pro-active, comprehensive manner."

States and localities have absorbed some of the costs that the Refugee Program and SLIAG will no longer pay for and in some cases have been able to expand services. However, most states' ability to maintain the level of services provided under these two programs is very limited, particularly in light of the troubled fiscal climate in many states. For example, Colorado said that it recently passed an amendment that limits state taxes and expenditures, precluding any possibility of replacing lost federal refugee and SLIAG money with state funds.

Implications for Policy Reform

National debate about the costs and benefits of immigration has escalated, bringing immigration to the forefront of policy discussions. This debate has led to proposals to bar immigrants from receiving welfare and to demands from state governments for federal reimbursement of the costs of serving immigrants. In light of these developments, the type of impacts that have resulted from reduced Refugee Program funding as well as the lessons

learned here regarding impact aid to states and localities warrant attention.

As seen in the Refugee Program, when the period of availability of federal refugee cash and medical assistance was reduced, refugees turned to state and locally funded services such as General Assistance. Where refugees were not able to get state and locally funded services, they bore the brunt of the reductions. We also saw that reduced health services resulted in increased use of emergency services. These services are often more expensive to deliver than preventive or primary care and are paid for partly by states and localities.

Census data reveal that although refugees have high welfare usage rates soon after their arrival, their use of welfare declines over the long term. At the same time, other immigrants have low welfare usage rates soon after arrival but their rates increase over the long term.[17] To some extent this difference is explained by the fact that refugees are provided special assistance upon arrival while other immigrants are effectively barred from receiving public assistance for several years after arrival.[18] Nonetheless, these trends may indicate that investment in refugees soon after they arrive through job and language training may pay off in the long run as shown by their declining welfare usage rates.

State efforts to seek reimbursement for immigrants' costs, as well as proposals to restrict immigrant welfare eligibility, raise questions about the federal role in paying for immigrant costs. Changes in federal welfare eligibility may not affect immigrant eligibility for state and local services.[19] Therefore, the proposed changes to restrict immigrant eligibility for federal benefits are likely to drive up use of state and local benefits, as seen with the Refugee Program. Those states with a generous benefit structure will incur greater costs than those without. Further, other research has found that the federal government receives more in taxes from immigrants than it pays out in services. But the reverse is true for many states and almost all localities.[20] These findings point to consideration of new federal strategies to offset state and local costs of immigrants.

In determining whether and how to offset costs, several issues must be considered, including for which immigrants and costs reimbursement is warranted and how to design the reimbursement or impact aid. SLIAG provides perhaps the most relevant example of such an impact aid grant to states.[21] SLIAG was successful at getting federal funds to state and local governments to offset certain costs. But SLIAG's design as a reimbursement program with burdensome documentation requirements made it difficult for states and localities to receive all the allotted funds. These requirements also resulted in a large share of the SLIAG funds paying for administrative efforts and not for services. Further, it is important to note that documenting services used by immigrants is particularly difficult because not all state and local programs screen for immigration status.

SLIAG provided a number of other lessons relevant to how impact aid funds might be distributed. The program's strict rules for not allowing funds to go to new services (with the exception of education and antidiscrimination outreach) chilled potential innovation in service delivery. Such innovation might help states and localities adapt their services to better meet the needs of the changing immigrant population. Further, the SLIAG experience suggests that flexibility in the funding formula for impact aid is necessary to accommodate changes in the immigrant population and in the costs of providing services. Finally, any potential future impact aid program could build on the public and private institutional capacity to serve newcomers created under the Refugee Program and SLIAG.

Conclusion

The Refugee Program and SLIAG have had an important effect on many states' capacity to serve newcomers. For some states they have been the impetus for the creation of state-level offices aimed at serving all newcomers. The programs have also helped state and local governments further understand the demand for services among newcomer populations, create networks of providers and, to some extent, make their mainstream institutions more accessible to newcomers' needs. They have also made important investments in non-governmental organizations that serve immigrants.

Decreased Refugee Program funding has shifted costs to states and localities, particularly those with large numbers of refugees and high costs of providing services. Because states do not all track the participation of refugees in public assistance programs, it is impossible to know the exact cost-shifts resulting from the Refugee Program reduc-

tions. California, the state with the largest documented costs, estimates its AFDC expenditures for refugees in the country less than three years at $81 million for FY 1994. Washington reported a total of $8.8 million in costs for AFDC, Medicaid and General Assistance for FY 1991. Florida, another state with large numbers of refugees, reported only $585,000 in costs for AFDC and Medicaid in that year. These results suggest that reductions in Refugee Program funding have resulted in significant cost-shifts to some states, particularly when viewed over the long term as annual costs are compounded. They also point to the need for better tracking of the costs of providing services to refugees and immigrants in order to better assess the impact of these populations on the public coffers.

Declining Refugee Program funds have resulted in reduced public assistance, social services, and health services in many states. Though a few states, primarily those with smaller refugee populations, have been able to maintain or expand some social services, these services are limited in the extent to which they can fully meet newcomers' basic health and educational needs.

States were more likely to cut language services than any other type of social service. These cuts have come at a time when growing limited English proficient populations are in many states straining public resources for language instruction. Where refugees do get language instruction through the federal-state funded adult education system, costs are again being shifted to states.

Despite the deferrals of SLIAG funding, all of the promised funds appear likely to go to the states. However, burdensome federal documentation requirements led some states to simply absorb costs rather than ask for reimbursement. In a few instances, states were unable to meet documentation standards, resulting in some unreimbursed costs.

Finally, the Refugee Program and SLIAG provide some insights on the current debate about the costs of providing services to newcomers and the federal government's shrinking role in paying for those services. Proposals to cut immigrants off federal welfare would likely result in greater use of state and local services. These proposals, as well as recent lawsuits brought by several states requesting reimbursement for the costs of immigrants, underscore both the mismatch between immigration policy and immigrant policy and the need for more comprehensive thinking about what the country's federal immigrant policy *should* look like.

NOTES

1. For a broader discussion of federal immigrant policy see Michael Fix and Wendy Zimmermann, *After Arrival: An Overview of Federal Immigrant Policy in the United States*, The Urban Institute, July 1993. For an analysis of state level immigrant policy see Wendy Zimmermann and Michael Fix, *Immigrant Policy in the States: A Wavering Welcome*, The Urban Institute, July 1993.

2. We also learned from the experiences of the Maryland Office for New Americans and the Oregon State Refugee Office, which conducted statewide surveys to collect data on the services provided to newcomers. While these surveys yielded some interesting information from the states, it was clear that few programs collected reliable data on the use of services by immigrants and, therefore, such a survey on a national level would not be fruitful.

3. The federal government usually pays about half the costs of AFDC and Medicaid, but the exact amount varies by state. For example, the federal government pays 64 percent of Texas' AFDC costs versus 50 percent of California's.

4. Beginning in 1982 RCA/RMA was available for only 18 months, but the cost of providing assistance to refugees under a state or local General Assistance program, if available, was fully reimbursed for the subsequent 18 months.

5. The inclusion of two-parent families with children in the AFDC Unemployed Parent Program has meant that more refugees qualify for that program and fewer refugees receive payments from the federal refugee cash and medical assistance program.

6. See Lin C. Liu, *IRCA's State Legalization Impact Assistance Grants (SLIAG): Early Implementation*, RAND Note, N-3270-FF, Santa Monica, Calif: RAND, 1991.

7. Immigrants' eligibility for the SSI program, which provides assistance to the elderly, blind and disabled, was limited by recent legislation. The deeming period for SSI, or the time during which an immigrant's sponsor's income is deemed to be that of the immigrant for purposes of eligibility, was extended from three to five years until 1996. The Clinton welfare reform plan would limit immigrant eligibility by extending the deeming period from 3 to 5 years for AFDC and Food Stamps and would make the extension for SSI permanent. In addition, the Republican welfare reform bill, H.R. 3500, proposed much broader restrictions, making all non-citizens ineligible for most public assistance except for refugees who would be eligible for six years after becoming permanent residents and immigrants over age 75 who have been legal residents for at least five years. Suits have been filed by Florida for the costs of providing a range of services to legal and undocumented immigrants, *Chiles v. U.S.*, No. 94-____ (S.D. Fla.)(filed Apr. 11, 1994); by California for the costs of incarcerating and providing health care services to undocumented immigrants, *California v. U.S.*, No. 940674K(CM)(S.D. Cal.)(filed Apr. 29, 1994), *California v. U.S.*, No. 94-3561LGB(MCX)(C.D.Cal.)(filed May 3, 1994), and by Arizona for the costs of incarcerating undocumented immigrants *Arizona v. U.S.*, No. DIV 94-0866PHXSMM (D.Ariz.)(filed May 2, 1994).

8. For the Refugee Program survey the three categories are: states that received over 5,000 refugees in FY 92; states that received between 1,000 and 5,000 and states that received under 1,000. For analysis of the SLIAG portion of the survey the three categories are: states that had more than 150,000 legalization applicants (including those who had been in the country for at least five years [pre-82s] and those who legalized under the special agricultural worker provision [SAWs]); states that had between 12,000 and 150,000; states that had fewer than 12,000. While it should be remembered that other groupings would also be of interest, these categories are in line with the numbers of refugees received by states over the past decade.

9. For an analysis of the costs and revenues of immigrants in one locality, see Clark, Rebecca and Jeffrey Passel, *How Much Do Immigrants Pay in Taxes? Evidence from Los Angeles County*, Washington, D.C.: The Urban Institute, PRIP-UI-26, August 1993.

10. The report is based on costs as they were reported by the state Refugee Program coordinators; therefore, these costs are only as accurate as the actual or estimated costs that they have provided.

11. U.S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs: 1993 Green Book*, July 7, 1993, pp. 683-84.

12. These tables do not reflect actual refugee welfare rates. Rather, they are estimates of refugee welfare participation based on 1990 census counts of those arriving after 1986, who reported using public assistance and who were born in the major refugee-sending countries: Albania, Poland, Romania, USSR, Afghanistan, Cambodia, Iraq, Laos, Vietnam, Cuba and Ethiopia.

13. Ron Spendal, Oregon's refugee coordinator, estimated the state-by-state cost-shifts by using FY 1988 costs and adjusting for changes in refugee arrival numbers and changes in state costs. His study estimated cost-shifts to states for FY 1990 at $85,346,739.

14. (Pub. L. No. 102-394, 106 Stat. 1792) amending IRCA Sect. 204(b)(4), reported in Interpreter Releases, October 26, 1992.

15. Data from the Office of Refugee Resettlement, U.S. Department of Health & Human Services, January 14, 1993.

16. Ibid.

17. U.S. General Accounting Office, *Funding for State Legalization Impact Assistance Grants Program*, GAO/HRD-91-109, Washington, D.C., May 1991.

18. About three-quarters of the rejected costs were for medical assistance and most of the rest was for cash assistance.

19. See Marion Nichols, Jon Dunlap, Scott Barkan, *National General Assistance Survey, 1992*, Washington, D.C.: Center on Budget and Policy Priorities and the National Conference of State Legislatures, December 1992.

20. Ibid.

21. These calculations are based on the number of refugees arriving in a year and federal Refugee Program obligations for the same year. They do not necessarily correspond to the number of refugees using those services in that year.

22. U.S. Census, PUMS, 1990. Because the census does not identify refugees we used foreign-born persons from countries that sent large numbers of refugees over the decade as a proxy for refugees. These countries are Albania, Poland, Romania, USSR, Afghanistan, Cambodia, Iraq, Laos, Vietnam, Cuba and Ethiopia.

23. Chiswick, Barry R. and Paul W. Miller, "Language in the Immigrant Labor Market," *Immigration, Language and Ethnicity*, edited by Barry R. Chiswick, Washington, D.C.: The American Enterprise Institute Press, 1992, p. 264.

24. Office of Refugee Resettlement, U.S. Department of Health and Human Services, *Annual Report FY 1992*, p. 55.

25. Forrest P. Chisman, Heide Spruck Wrigley, Danielle T. Ewen, "ESL and the American Dream: A Report on an Investigation of English as a Second Language Service for Adults," Southport Institute for Policy Analysis, 1993.

26. U.S. Department of Education, Division of Adult Education and Literacy, *Adult Education Delivery System Trends: Program Year 1990-1991*, April 1993.

27. Not all refugee coordinators knew whether there were waiting lists for ESL in their state. For this reason, we cannot report a complete list of states with waiting lists.

28. Chisman, Spruck Wrigley, Ewen, 1993.

29. Office of Refugee Resettlement, U.S. Department of Health and Human Services, *Annual Report: FY 1992*, Washington, D.C., 1992, p. A-3.

30. Wendy Zimmermann and Michael Fix, *Immigrant Policy in the States: A Wavering Welcome*, The Urban Institute, July 1993.

31. The federal anti-dumping statute is designed to prevent hospitals from transferring or discharging people in need of emergency care because they lack private health insurance. 42 U.S.C. Sect. 1395dd. Many states also have similar anti-dumping laws. See Michele Melden, Michael Parks, and Laura Rosenthal, "Health Care Rights of the Poor: An Introduction," *Clearinghouse Review*, November 1991, pp. 896-903.

32. In FY 1992 ORR awarded $3.56 million to 30 states under the Job Links discretionary program. These funds are intended to provide supplementary social service funding to link employable refugees with jobs in communities that have good economic opportunities. ORR awarded $48.8 million for targeted assistance for employment and other services for refugees in local areas with unusually large refugee populations, highly concentrated refugee populations and with high use of public assistance. Of the total, $19 million was specially earmarked for Florida to provide health care to refugees at Jackson Memorial Hospital and to help support the costs of educating refugee children in the Dade County public school system.

33. Michael Fix and Jeffrey Passel with Maria Enchautegui and Wendy Zimmermann, *Immigration and Immigrants: Setting the Record Straight*, The Urban Institute, May 1994; and Frank D. Bean, Kyung Tae Park, Jennifer V.W. Van Hook, Jennifer Glick, *Welfare Recipiency Among Immigrants: Implications for U.S. Immigrant Policy*, Washington, D.C.: The Urban Institute, January 1994.

34. Two provisions in current law act to deter recent immigrants from applying for and receiving federal welfare benefits. The first is the deeming provision, under which the income of an immigrant's sponsor is "deemed" to also be the income of the immigrant for purposes of eligibility for the first three years of residence. Second, an immigrant who is found to be a "public charge" in the first five years of residence may be deported.

35. However, the Clinton welfare reform plan proposes to allow states to disqualify from their General

Assistance programs any legal immigrants ineligible for federal benefits. "Work and Responsibility Act of 1994," HR4605/S2224.

36 Fix, Passel, et al, 1994.

37 Another impact assistance grant targeted to immigrants is provided under the Emergency Immigrant Education Act (EIEA). EIEA funds, budgeted at about $35 million for FY 1995, are distributed to school districts based on the number of children in the district who have been in the country three years or less.

References

Bean, Frank D., Kyung Tae Park, Jennifer V.W. Van Hook, Jennifer Glick. "Welfare Recipiency Among Immigrants: Implications for U.S. Immigrant Policy." Washington, D.C.: The Urban Institute, January 1994.

Chisman, Forrest P., Heide Spruck Wrigley, Danielle T. Ewen. "ESL and the American Dream: A Report on an Investigation of English as a Second Language Service for Adults." Washington, D.C.: Southport Institute for Policy Analysis, 1993.

Chiswick, Barry R. and Paul W. Miller, "Language in the Immigrant Labor Market." *Immigration, Language and Ethnicity*, ed. Barry R. Chiswick. Washington, D.C.: The American Enterprise Institute Press, 1992.

Clark, Rebecca and Jeffrey Passel. "How Much do Immigrants Pay in Taxes? Evidence from Los Angeles County." Washington, D.C.: The Urban Institute, PRIP-UI-26, August 1993.

Fix, Michael, Jeffrey Passel with Maria Enchautegui and Wendy Zimmermann. *Immigration and Immigrants: Setting the Record Straight*. Washington, D.C.: The Urban Institute, May 1994.

Fix, Michael, and Wendy Zimmermann. "After Arrival: An Overview of Federal Immigrant Policy in the United States." Washington, D.C.: The Urban Institute, July 1993.

Liu, Lin C. "IRCA's State Legalization Impact Assistance Grants (SLIAG): Early Implementation." RAND Note, N-3270-FF, RAND: Santa Monica, CA, 1991.

Marzahl, David. "The Immigration Reform and Control Act Revisited: The Role of Education in the Legalization Program in Illinois." Travelers and Immigrants Aid of Chicago and The Chicago Coalition for Immigrant and Refugee Protection, August 1990.

Melden, Michele, Michael Parks, and Laura Rosenthal. "Health Care Rights of the Poor: An Introduction." *Clearinghouse Review*, November 1991.

Nichols, Marion, Jon Dunlap, Scott Barkan. "National General Assistance Survey, 1992." Washington, D.C.: Center on Budget and Policy Priorities and the National Conference of State Legislatures, December 1992.

Parker, Theresa. Testimony presented to the Subcommittee on Human Resources of the Committee on Ways and Means, November 15, 1993.

Spendal, Ron. Letter on state refugee costs, Oregon State Refugee Coordinator, Adult and Family Services Division, Oregon Department of Human Resources, January 11, 1990.

U.S. Department of Education, Division of Adult Education and Literacy. "Adult Education Delivery System Trends: Program Year 1990-1991." April 1993.

U.S. Department of Health and Human Services, Office of Refugee Resettlement. "Annual Report FY 1992." 1992.

U.S. Department of Health and Human Services, Office of Refugee Resettlement. "Annual Report FY 1994." 1994.

U.S. General Accounting Office. "Funding for State Legalization Impact Assistance Grants Program." GAO/HRD-91-109, May 1991.

U.S. House of Representatives, Committee on Ways and Means. "Overview of Entitlement Programs: 1993 Green Book." July 7, 1993.

Vialet, Joyce C. "Refugee Admissions and Resettlement Policy." *Congressional Research Service Issue Brief*, March 3, 1992.

Wilson, Pete. "Governor's Budget 1993-94: From Adversity to Opportunity." California, January 1993.

Zimmermann, Wendy and Michael Fix. "Immigrant Policy in the States: A Wavering Welcome." Washington, D.C.: The Urban Institute, July 1993.

APPENDIX A
CHRONOLOGY OF IMMIGRATION LEGISLATION

1920s A ceiling was placed on most immigration, and a per-country quota was established based on the national origin of the U.S. population in the 1910 census.

1952 **The Immigration and Nationality Act**, P.L. 82-414 (also known as the McCarran-Walter Act) was the first codification of immigration and nationality law and is still the basic code. It set a ceiling of 150,000 for non-Western hemisphere countries and established a preference system for distributing visas within each country's allotment (favoring highly skilled workers). Regarding refugees, Section 212(d) (5)) empowered the U.S. Attorney General to admit for up to two years any person whose admission would be in the American interest. Originally meant for emergencies (medical treatment), it has been broadly interpreted to permit mass admission of refugees.

1965 **The Immigration Act of 1965** ended the national origins quota system and added a new preference system oriented toward family reunification. Innovations in the act were a ceiling on visas for immigration from the Western hemisphere at 120,000, 170,000 for all other countries, and no more than 20,000 from one country. Also, all nonrelative and nonrefugee immigrants were required to obtain a labor clearance certifying that American workers were not available and immigrants would not lower prevailing wages and working conditions. The act also established a preference for refugees, which was limited to people fleeing from a communist-dominated country or the Middle East.

1978 The two ceilings for immigrants from "Western hemisphere" and "other country" were combined into a single annual ceiling of 290,000 visas.

1980 **The Refugee Act**, P.L. 96-212, brought the definition of refugee into conformity with the international definition; it dropped the seventh preference that had been established for refugees and reduced the worldwide quota to 270,000. Refugee admissions were separated from immigration and organized as a separate process. Refugees became entitled to certain federally reimbursable social and medical services (the length of reimbursement has decreased from 36 to eight months for special refugee assistance, and from 36 to 0 months for categorical programs). Appropriations were authorized for three years. Also, 5,000 asylees a year were allowed to adjust their status from asylee to permanent resident. The President, in consultation with Congress, sets admission levels for refugees (125,000 for FY 1990); there are six priority levels for determining who may enter.

1982 **Refugee Assistance Amendments**, P.L. 97-363, extended authorization of appropriations for refugee assistance and domestic resettlement for one year (FY 1983). (FY 1984 and FY 1985 were authorized through continuing resolutions.)

1986 **Refugee Assistance Extension Act**, P.L. 99-605, extended funding for two years for domestic resettlement activities under the Refugee Act of 1980 (FY 1986 and FY 1987). The appropriations included $100 million for social services; $50 million for targeted assistance to heavily affected areas; and "such sums as necessary" for cash and medical assistance, special educational assistance, matching grant program, and administrative costs. Since 1975, the federal government has maintained a policy of reimbursing state and local governments for 100 percent of the costs they incur in resettling refugees "subject to appropriations." (FY 1988 was funded through a continuing resolution, P.L. 100-202. Total funding for states and other grantees under the refugee domestic assistance program was $347 million.)

1986 **Immigration Reform and Control Act**, P.L. 99-603, (popularly known as the Simpson-Rodino Act or IRCA), was signed into law November 6, 1986. Its purpose was to control illegal or

undocumented immigration, chiefly by establishing penalties for employment of undocumented aliens; and to provide legalization of status of certain aliens illegally resident in the United States. Nearly three million undocumented persons were granted amnesty under this act.

1988 **Immigration Amendments**, P.L. 100-658, were enacted to promote diversification in the legal immigration system by providing for issuance over a two-year period of 50,000 visas for countries that have sent few immigrants over recent years.

1989 **Immigration Nursing Relief Act**, P.L. 101-238, allows State Legalization Impact Assistance Grant (SLIAG) funds to be used for public education and outreach for the Phase II legalization process under IRCA and for outreach regarding unfair discrimination in employment.

1990 **The Immigration Act of 1990**, P.L. 101-649, increased the overall immigration ceiling for family reunification and employment to 675,000 entrants per year. Immediate relatives of U.S. citizens (spouses, minor children, and parents) are now counted under the ceiling, although there is no limit on the number of immediate relatives who may enter. The legislation created 55,000 "diversity" visas for countries disadvantaged under the current system (primarily Europe); increased the per country limit of 20,000 visas to 25,000; created a "temporary protected status" that allows nationals fleeing natural or man-made disasters to remain in the United States until their countries are deemed safe; and permitted work authorization for spouses and children of those granted amnesty under the 1986 act. The act permits 10,000 asylees to adjust to permanent resident status each year.

1993 P.L. 103-37 reauthorized appropriations for refugee assistance for FY 1993 and FY 1994. The current appropriations level is $400 million for the domestic refugee resettlement program.

APPENDIX B[1]
CONTACTS ON IMMIGRATION AND IMMIGRANT POLICY

STATE AND LOCAL GOVERNMENT

Alabama
JOEL SANDERS
State Refugee Coordinator
Department of Human Resources
50 Ripley Street
Montgomery, AL 36130
(205) 242-1950

Alaska
RITA HOLDEN
Alaska Refugee Outreach
4502 Cassin Drive
Anchorage, AK 99507
(907) 561-0246

Arizona
TRI HUU TRAN
State Refugee Coordinator
Refugee Resettlement Program
P.O. Box 6123, Site Code 0862
Phoenix, AZ 85005
(602) 542-6600

Arkansas
HYGINIUS UKADIKE
Manager, Refugee Resettlement Program
P.O. Box 1437, Slot 1225
Little Rock, AR 72203
(501) 682-8263

California
JOHN CULLEN
Director of Human Services
Merced County
P.O. Box 112
Merced, CA 95340
(209) 385-3000

JOAN DARRAH
Mayor of Stockton
425 N. El Dorado Street
Stockton, CA 95202
(209) 944-8244

SUSAN GOLDING
Mayor of San Diego
202 C Street
San Diego, CA 92101
(619) 236-6330

FRANK JORDAN
Mayor of San Francisco
City Hall - Room 200
San Francisco, CA 94102
(415) 554-6141

BRUCE KENNEDY
State Refugee Coordinator
Employment and Immigration Programs Branch
Department of Social Services
744 P Street, MS 19-46
Sacramento, CA 95814
(916) 324-1576

ANN KLINGER
Merced County Supervisor
2222 M Street
Merced, CA 95340
(209) 385-7366

BECKY LAVALLY
Senate Office of Research
1020 N Street, Suite 565
Sacramento, CA 95814
(916) 445-1727

BILL MCFADDEN
Department of Social Services
Los Angeles County
12860 Crossroads Parkway South
City of Industry, CA 91746
(310) 908-8457

RICHARD RIORDAN
Mayor of Los Angeles
200 N. Spring Street
Los Angeles, CA 90012
(213) 485-3311

[1] This list of contacts include the state refugee coordinators, the members of the U.S. Conference of Mayors' Task Force on Immigration, the members of the Immigrant Policy Project's Expert Panel, and other key immigrant policy contacts suggested by the Immigrant Policy Project's Governing Board (the American Public Welfare Association, the National Association of Counties, the National Governors' Association, the National Conference of State Legislatures, and the U.S. Conference of Mayors).

CHARLES SMITH
Mayor of Westminster
8200 Westminster Boulevard
Westminster, CA 92683
(714) 898-3311

ART TORRES
California State Senator
State Capitol, Room 2080
Sacramento, CA 95814
(916) 445-3456

DORIS WARD
Tax Assessor
San Francisco County
City Hall, Room 289
San Francisco, CA 94102
(415) 554-4851

PETE WILSON
Governor of California
State Capitol
Sacramento, CA 95814
(916) 445-2841

Colorado
LAURIE BAGAN
State Refugee Coordinator
Refugee & Immigrant Services Program
Department of Social Services
789 Sherman Street, Suite 250
Denver, CO 80203
(303) 863-8211

Connecticut
LUCIO HIDALGO
State Refugee Coordinator
Department of Human Resources
1049 Asylum Drive
Hartford, CT 06115
(203) 566-4329

Delaware
CELENA HILL
State Refugee Coordinator
Division of Social Services, P.O. Box 906
New Castle, DE 19720
(302) 577-4453

District of Columbia
SHARON PRATT KELLY
Mayor of Washington, D.C.
District Building
Washington, D.C. 20004
(202) 727-6319

THELMA WARE
State Refugee Coordinator
Office of Refugee Resettlement
645 H Street, NE, Suite 4001
Washington, D.C. 20002
(202) 724-4820

Florida
SEYMOUR GELBER
Mayor of Miami Beach
1700 Convention Center Drive
Miami Beach, FL 33139
(305) 673-7030

ALEX PENELAS
Dade County Commissioner
111 NW 1st Street, Suite 220
Miami, FL 33128
(305) 375-5071

ANGELO PARRINO
Department of Public Assistance
5550 W. Idlewild
Tampa, FL 33614
(305) 375-5071

NANCY KELLEY WITTENBERG
State Refugee Coordinator
Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Bldg. 1, Room 423
Tallahassee, FL 32399-0700
(305) 488-3791

Georgia
EVERETT GILL
State Refugee Coordinator
DFCS - Special Programs Unit
Department of Human Resources
2 Peachtree Street, NE, 13th Floor
Atlanta, GA 30303
(404) 657-3425

Hawaii
LINDA CROCKETT LINGLE
Mayor of Maui
200 S. High Street
Wailuku, Maui, HI 96793
(808) 243-7855

DWIGHT OVITT
Assistant State Refugee Coordinator
Office of Community Services
335 Merchant Street, Room 101
Honolulu, HI 96813
(808) 586-8675

Idaho
JAN REEVES
Manager, Refugee Services Program
Bureau of Family Self Support
450 W. State Street, 7th Floor
Boise, ID 83720
(208) 334-6579

Illinois
RICHARD M. DALEY
Mayor of Chicago
121 N. LaSalle Street
Chicago, IL 60602
(312) 744-3300

ED SILVERMAN
Refugee Program Bureau Manager
Bureau of Refugee & Immigrant Services
527 S. Wells Street, Suite 500
Chicago, IL 60607-3922
(312) 793-7120

Indiana
VICKI STUMP
Department of Welfare
238 S. Meridian Street, 4th Floor
Indianapolis, IN 46204
(317) 232-4943

Iowa
WAYNE JOHNSON
Chief, Bureau of Refugee Services
1200 University Avenue, Suite D
Des Moines, IA 50314-2330
(515) 283-7904

Kansas
PHILIP GUTIERREZ
Employment Preparation Services/Refugee
300 SW Oakley, West Hall
Topeka, KS 66606
(913) 296-5157

Kentucky
J. R. NASH
Divisions of Programs Management
Department of Social Services
275 E. Main Street, 6th Floor
Frankfort, KY 40621
(502) 564-6750

Louisiana
STEVE THIBODEAUX
State Refugee Coordinator
Office of Community Services
2026 St. Charles Avenue, Room 202
New Orleans, LA 70130
(504) 568-8958

WAYNE WADDELL
Caddo Parish Commissioner
3221 Green Terrace Road
Shreveport, LA 71118
(318) 687-5319

Maine
DAN TIPTON
State Refugee Coordinator
Department of Human Services
Statehouse Station #1
221 State Street
Augusta, ME 04333
(207) 287-5060

Maryland
FRANK BIEN
State Refugee Coordinator
Office for New Americans
311 W. Saratoga Street, Room 222
Baltimore, MD 21201
(410) 333-0180

Massachusetts
THOMAS FORD
Acting Director
Office for Refugees and Immigrants
2 Boylston Street, Suite 202
Boston, MA 02116
(617) 727-7888

Michigan
JUDI HALL
State Refugee Coordinator
Department of Social Services
Michigan Plaza, Suite 462
1200 6th Street
Detroit, MI 48226
(313) 256-1740

Minnesota
BONNIE BECKER
State Refugee Coordinator
Refugee & Immigrant Assistance Division
444 Lafayette Road
St. Paul, MN 55155-3837
(612) 296-2499

Mississippi
ROBIN SMITH
State Refugee Coordinator
Department of Public Works, P.O. Box 352
Jackson, MS 39205
(601) 354-6658

Missouri
EMANUEL CLEAVER
Mayor of Kansas City
414 East 12th Street, 29th Floor
Kansas City, MO 64106
(816) 274-2595

PATRICIA HARRIS
State Refugee Coordinator
Division of Family Services, P.O. Box 88
Jefferson City, MO 65103
(314) 751-2456

Montana
JIM ROLANDO
University of Montana
Department of Social Work
Missoula, MT 59812
(406) 243-2336

Nebraska
MARIA DIAZ
State Refugee Coordinator
Department of Social Services
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-9200

Nevada
ANTHOULA SULLIVAN
State Welfare Division
Department of Human Resources
2527 N. Carson Street
Carson City, NV 89701
(702) 687-4715

New Hampshire
PATRICIA GARVIN
State Refugee Coordinator
Governor's Ofc. of Energy & Human Resources
57 Regional Drive
Concord, NH 03301
(603) 271-2611

New Mexico
PAUL LUCERO
Income Support Division
Department of Human Services
P.O. Box 2348
Santa Fe, NM 87504-22348
(505) 827-7248

New Jersey
CARDELL COOPER
Mayor of East Orange
44 City Hall Plaza
East Orange, NJ 07019
(201) 266-5151

AUDREA DUNHAM
State Refugee Coordinator
Department of Human Services
CN 717, 50 E. State Street
Trenton, NJ 08625
(609) 984-3154

SHARPE JAMES
Mayor of Newark
920 Broad Street
Newark, NJ 07102
(201) 733-6400

LARRIE W. STALKS
County Register
Essex County
131 Raymond Avenue
South Orange, NJ 07079
(201) 642-0614

WILLIAM WALDMAN
Commissioner
Department of Human Services
222 S. Warren Street, CN 700
Trenton, NJ 08625
(609) 292-3717

New York
JOHN BATTISTONI
Commissioner, Social Services
Dutchess County
60 Market Street
Poughkeepsie, NY 12601
(914) 431-5000

MARK LEWIS
State Refugee Coordinator
Department of Social Services
40 N. Pearl Street
Albany, NY 12243
(518) 432-2517

ALBERT VANN
New York State Representative
Legislative Office Building, Room 422
Albany, NY 12248
(518) 455-5474

North Carolina
ALICE COLEMAN
State Refugee Coordinator
325 N. Salisbury Street
Raleigh, NC 27603
(919) 733-4650

RICHARD W. JACOBSEN
Director of Social Services
Mecklenberg County
301 Billingsley Road
Charlotte, NC 28211
(704) 336-3020

North Dakota
KATHY NIFDEFFER
Refugee Program Administrator
Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505
(701) 224-4808

Ohio
ERICA TAYLOR
State Refugee Coordinator
Bureau of Refugee Services
Rhodes State Office Tower, 30th Floor
30 East Broad Street
Columbus, OH 43266-0423
(614) 466-5848

Oklahoma
KAREN RYNEARSON
Refugee Program Manager
Department of Human Services
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-4092

Oregon
LUIS CARABALLO
Director
Office of Immigration Programs
155 Cottage Street, NE
Salem, OR 97310
(503) 373-7679

KEVIN CONCANNON
Director
Department of Human Resources
318 Public Service Building
Salem, OR 97310
(503) 378-3033

VERA KATZ
Mayor of Portland
1220 SW 5th Street, PAC West
Portland, OR 97204
(503) 823-4120

JOHN MULLEN
Department of Social Services
Clackamas County
P.O. Box 68369
Oak Grove, OR 97268
(503) 655-8640

RON SPENDAL
State Refugee Coordinator
Adult and Family Services
500 Summer Street, NE
Salem, OR 97310-1013
(503) 945-6099

Pennsylvnia
RON KIRBY
State Refugee Coordinator
Bureau of Contract & Program Support Services
Health & Welfare Building, Room 529
P.O. Box 2675
Harrisburg, PA 17120
(717) 783-7535

Rhode Island
CHRISTINE MARSHALL
State Refugee Coordinator
Department of Human Services
275 Westminster Mall, 4th Floor
Providence, RI 02903
(401) 277-2551

South Carolina
BERNICE SCOTT
State Refugee Coordinator
Refugee & Legalized Alien Services
Department of Social Services, P.O. Box 1520
Columbia, SC 29202-1520
(803) 737-5941

South Dakota
PEARL PRUE
State Refugee Coordinator
Department of Social Services
Kneip Bldg, 700 N. Governor's Drive
Pierre, SD 57501
(605) 773-3493

Tennessee
STEVE MEINBRESSE
State Refugee Coordinator
Department of Human Services
400 Deaderick Street, Citizen's Plaza
Nashville, TN 37248-9500
(615) 741-5949

Texas
BARBARA CREWS
Mayor of Galveston
823 Rosenberg
Galveston, TX 77553
(409) 766-2103

SAUL N. RAMIREZ, JR.
Mayor of Laredo
1110 Houston Street
Laredo, TX 78040
(210) 791-7300

ANN RICHARDS
Governor of Texas
P.O. Box 12428, Capitol Station
Austin, TX 78711
(512) 463-2000

MARGUERITE RIVERA HOUZE
Texas Office of Immigration & Refugee Affairs
9101 Burnet Road, Suite 216
Austin, TX 78758
(512) 873-2400

NELSON WOLFE
Mayor of San Antonio
P.O. Box 839966
San Antonio, TX 78283-3966
(210) 299-7060

Utah
SHERMAN ROQUIERO
State Refugee Coordinator
Department of Human Services
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-4091

Vermont
CHARLES SIMPSON
State Refugee Coordinator
Refugee Resettlement Program
59 Pearl Street
Burlington, VT 05401
(802) 658-1120

Virginia
KATHY COOPER
State Refugee Coordinator
Department of Social Services
730 E. Broad Street
Richmond, VA 23299-8699
(804) 692-1206

Washington
THUY VU
State Refugee Coordinator
Division of Refugee Assistance
P.O. Box 45420
Olympia, WA 98504-5420
(206) 438-8385

West Virginia
CONA CHATMAN
State Refugee Coordinator
Department of Human Resources
State Capitol Complex, Bldg. 6, Room 817
Charleston, WV 25305
(304) 348-8290

Wisconsin
SUSAN LEVY
State Refugee Coordinator
Refugee Assistance and Poverty Office
1 W. Wilson Street, Room 330
P.O. Box 7935
Madison, WI 53707
(608) 266-0578

Wyoming
JEANNE JERDING
State Refugee Coordinator
Department of Family Services
811 N. Glenn Road
Casper, WY 82601
(307) 265-4411

FEDERAL GOVERNMENT

U.S. COMMISSION ON IMMIGRATION REFORM
*SUSAN MARTIN
Executive Director
1825 Connecticut Avenue, NW, Suite 511
Washington, D.C. 20009-5708
(202) 673-5348

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
*LAVINIA LIMÓN
Director, Office of Refugee Resettlement
Administration for Children and Families
370 L'Enfant Promenade, SW
Washington, D.C. 20447-0001
(202) 401-9246

U.S. DEPARTMENT OF JUSTICE
*DORIS MEISSNER
Commissioner
Immigration and Naturalization Service
425 I Street, NW, Suite 7100
Washington, D.C. 20536
(202) 514-1900

*ROBERT BACH
U.S. Immigration and Naturalization Service
425 I Street, NW, Room 6038
Washington, D.C. 20536
(202) 616-7767

COMMUNITY RELATIONS SERVICE
5550 Friendship Boulevard
Suite 330
Chevy Chase, MD 20815
(301) 492-5929

U.S. DEPARTMENT OF LABOR
LINDSAY LOWELL
Immigration Policy and Research
Room S5325
200 Constitution Avenue, NW
Washington, D.C. 20210
(202) 219-9098

U.S. DEPARTMENT OF STATE
TIMOTHY E. WIRTH
Undersecretary of State for Global Affairs
2201 C Street, NW, Room 7250
Washington, D.C. 20520
(202) 647-6240

*THERESA RUSCH
Bureau of Population, Refugees & Migration
SA-1, Room 1200
22nd and C Streets, NW
Washington, D.C. 20524
(202) 663-1047

NON-GOVERNMENTAL ORGANIZATIONS

*MICHAEL FIX
The Urban Institute
2100 M Street, NW
Washington, D.C. 20037
(202) 857-8517

*CHARLES KEELY
The Center for Immigration Policy and Refugee Assistance
Georgetown University - POB 2298
Washington, D.C. 20057
(202) 687-7932

*CECILIA MUÑOZ
National Council of La Raza
810 First Street, NE, Suite 300
Washington, D.C. 20002-4205
(202) 289-1380

*DAVID NORTH
New TransCentury Foundation
3113 North Kensington Street
Arlington, VA 22207
(703) 241-1724

*Denotes members of the Immigrant Policy Project's Expert Panel

*DEMETRIOS PAPADEMETRIOU
The Carnegie Endowment for International Peace
2400 N Street, NW
Washington, D.C. 20037
(202) 862-7985

*FRANK SHARRY
National Immigration Forum
220 I Street, NE, Suite 220
Washington, D.C. 20002
(202) 544-0004

*RICK SWARTZ
Swartz and Associates
1869 Park Rd, NW
Washington, DC 20010
(202) 328-1313

*TSEHAYE TEFERRA
Ethiopian Community Development Council
1038 South Highland Street
Arlington, VA 22204
(703) 685-0510

*LUIS TORRES
InterAmerican Institute on Migration and Labor
Mount Vernon College
2100 Foxhall Road, NW
Washington, D.C. 20007
(202) 625-4686

CHARLES WHEELER
National Immigration Law Center
1636 W. 8th Street, Suite 205
Los Angeles, CA 90017
(213) 487-2531

JANA MASON
Immigration and Refugee Services of America
1717 Massachusetts Avenue, NW, Suite 701
Washington, D.C. 20036
(202) 797-2105

JOHN FREDRIKSSON
Lutheran Immigration and Refugee Services
122 C Street, NW, Suite 125
Washington, D.C. 20001
(202) 783-7509

RICHARD PARKINS
U.S. Catholic Conference
Migration and Refugee Services
3211 4th Street, NE
Washington, D.C. 20017-1194
(202) 541-3114

DIANA AVIV
Council of Jewish Federations
1640 Rhode Island Ave, NW, Suite 500
Washington, D.C. 20036
(202) 785-5900

DIANA BUI
Southeast Asia Resource Action Center
1628 16th Street, NW, Third Floor
Washington, D.C. 20009
(202) 667-4690

Selected References on Immigration and Immigrant Policy

Aleinikoff, Thomas A., and David A. Martin. *Immigration: Process and Policy*. 2nd ed. St. Paul, Minn.: West Publishing Co., 1991.

Bach, Robert L., and Doris Meissner. *Employment and Immigration Reform: Employer Sanctions Four Years Later*. 1st ed. Washington, D.C.: Carnegie Endowment for International Peace, 1990.

Bean, Frank D.; Barry Edmonston; and Jeffrey S. Passel, eds. *Undocumented Migration to the United States IRCA and the Experience of the 1980s*. Washington, D.C.: The Urban Institute for RAND Corp. 1990.

Bean, Frank D.; Charles B. Keely; and Georges Vernez. *Opening and Closing the Doors: Evaluating Immigration Reform and Control*. Washington, D.C.: The Urban Institute, 1989.

Borjas, George J. *Friends or Strangers: The Impact of Immigrants on the U.S. Economy*. Basic Books, USA. 1990.

Borjas, George J., and Richard B. Freeman, eds. *Immigration and the Work Force, Economic Consequences for the United States and Source Areas*. Vol. A. National Bureau of Economic Research Report. Chicago: University of Chicago, 1992.

Briggs, Vernon M. *Mass Immigration and the National Interest*. Armonk, N.Y.: M.E. Sharpe, Inc., 1992.

_____. *Immigration and the U.S. Labor Market: Public Policy Gone Awry*. Ithaca, N.Y.: Cornell University, 1992.

City of St. Paul. *Southeast Asian Refugees and U.S. Cities: Myths and Realities*. St. Paul, Minn., December 4, 1990.

Clark, Rebecca L., and Jeffrey S. Passel. *How Much Do Immigrants Pay in Taxes?: Evidence From Los Angeles County*. PRIP-UI-26. Washington, D.C.: Urban Institute, August 1993.

Commission for the Study of International Migration and Cooperative Economic Development. *Unauthorized Migration: An Economic Development Response*. Washington, D.C., July 1990.

Cortes, Michael. *California's Shadow Population: The Impact of Undocumented Immigrants from Latin America on State Health and Social Service Policies and Programs*. Berkeley: California Policy Seminar, August 1985.

Cose, Ellis. *A Nation of Strangers: Prejudice, Politics and the Populating of America*. New York: William Morrow and Co., Inc., 1992.

Eig, Larry M., and Joyce C. Vialet. "Alien Eligibility Requirements for Major Federal Assistance Programs. *CRS Report for Congress*. No. 93-1046A. Washington, D.C.: Congressional Research Service, December 8, 1993.

Ekstrand, Laurie E. *Immigration and Enforcement: Problems in Controlling the Flow of Illegal Aliens*. Washington, D.C., GAO, 1993.

Enchautegui, Maria E. *Immigration and County Employment Growth*. PRIP-IU-23. Washington, D.C.: The Urban Institute, August 1992.

Espenshade, Thomas J., and Eric S. Rothman. "Fiscal Impacts of Immigration to the United States". *Population Index*, Fall 1992, 381-415.

Fix, Michael, and Jeffrey S. Passel, with Maria E. Enchautegui and Wendy Zimmermann. *Immigration and Immigrants: Setting the Record Straight*. Washington, D.C.: The Urban Institute, May 1994.

Fix, Michael, and Jeffrey S. Passel. *The Door Remains Open: Recent Immigration to the United States and a Preliminary Analysis of The Immigration Act of 1990*. Washington, D.C.: The Urban Institute, January 1991.

Fix, Michael, and Wendy Zimmermann. *After Arrival: An Overview of Federal Immigrant Policy in the United States*. Washington D.C.: The Urban Institute, July 1993.

Fuchs, Lawrence H. *Immigration Policy and Ethnic Policies: An Agenda for Tomorrow*. Waltham, Mass.: Brandeis University, 1993.

Fuchs, Lawrence H. *The American Kaleidoscope: Race, Ethnicity and the Civic Culture*. Hanover, N.H.: The University Press of New England, 1990.

Keely, Charles B. *American Immigration—The Continuing Tradition*. Washington, D.C.: The Coordinating Committee for Ellis Island, Inc., 1989.

Los Angeles County Internal Services Department. *Impact of Undocumented Persons and Other Immigrants on Costs, Revenues and Services in Los Angeles County*. November 6, 1992.

Morosoff, Ellen. *Immigration and the Labor Force in New York State*. Albany: New York State Legislative Commission on Skills Development and Vocational Education, October 1991.

Muller, Thomas. *The Fourth Wave: California's Newest Immigrants*. Washington, D.C.: The Urban Institute Press, 1984.

Muller, Thomas. *Immigrants and the American City*. A Twentieth Century Fund Book. New York: New York University Press, 1993.

National Immigration Law Center. *Guide to Alien Eligibility for Federal Programs*. Los Angeles: National Immigration Law Center, 1993.

North, David S. *Aliens and the Regular and Irregular Labor Markets*. Immigration Policy and Research. Washington, D.C.: U.S. Deptartment of Labor, 1988.

North, David S. *IRCA Did Not Do Much to the Labor Market: A Los Angeles County Case Study*, Immigration Policy and Research Working Paper 10, U.S. Department of Labor, Bureau of Labor Affairs, November 1991.

Ortiz, Ronald J., and Joseph L. Salvo. *The Newest New Yorkers: An Analysis of Immigration into New York City During the 1980s*. New York: New York City Department of City Planning, June 1992.

Portes, Alejandro, and Ruben G. Rumbaut. *Immigrant America: A Portrait*. Berkeley: University of California Press, 1990.

Portes, Alejandro, and Min Zhou. "The New Second Generation: Segmented Assimilation and Its Variants." *The Annals of the American Academy of Political and Social Science*, (November 1993), 74-96.

Rumbaut, Ruben G. "Passages to America: Perspectives on the New Immigration." in *America at Century's End*, edited by Alan Wolfe. Berkeley: University of California Press.

Simon, Julian L. *The Economic Consequences of Immigration*. Washington, D.C.: The Cato Institute, 1989.

Simon, Rita J., and Susan H. Alexander. *Print Media, Public Opinion, and Immigration*. Westport, Conn.: Praeger Publishers, 1993.

Smith, Michael P., and Bernadette Tarallo. *California's Changing Faces: New Immigrant Survival Strategies and State Policy*. Berkeley: California Policy Seminar, October 1993.

Sorensen, Elaine; Frank D. Bean; Leighton Ku; and Wendy Zimmermann, eds. *Immigrant Categories and the U.S. Job Market: Do They Make a Difference?* 92-1 Ed. Washington, D.C.: The Urban Institute, 1992.

State and Local Coalition on Immigration. *America's Newcomers: A State and Local Policymaker's Guide to Immigration and Immigrant Policy* by Jonathan D. Dunlap. Issue Paper No. 1, Denver: National Conference of State Legislatures, February 1993.

State and Local Coalition on Immigration. *America's Newcomers: Health Care Issues for New Americans* by Jonathan C. Dunlap and Fay Hutchinson. Issue Paper No. 2, Denver: National Conference of State Legislatures, July 1993.

State and Local Coalition on Immigration. *America's Newcomers: Employment and Training Programs for Immigrants and Refugees* by Ann Morse. Issue Paper No. 3, Denver: National Conference of State Legislatures, October, 1993.

State and Local Coalition on Immigration. *America's Newcomers: Community Relations and Ethnic Diversity* by Ann Morse and Jonathan C. Dunlap. Issue Paper No. 4, Denver: National Conference of State Legislatures, April 1994.

State of California, Assembly Office of Research. *Summary Report: Assembly Select Committee on Statewide Immigration Impact*. Sacramento, May 1994.

State of California, Office of the Auditor General. *A Fiscal Impact Analysis of Undocumented Immigrants Residing in San Diego County*. Sacramento, August 1992.

State of California, Senate Office of Research. *Californians Together: Defining the State's Role in Immigration*. Sacramento, July 1993.

State of California, Senate Office of Research. *A Review of Selected Issues Relating to Undocumented Persons in San Diego*. Sacrament, January 1991.

State of Florida, Executive Office of the Governor and the Florida Advisory Council on Intergovernmental Relations. *The Unfair Burden: Immigration's Impact on Florida*. Tallahassee, March 1994.

State of Florida, Department of Health and Rehabilitative Services. *Refugee Programs Update*. Vol. IV, no. 2, Summer 1993.

State of Florida, Department of Health and Rehabilitative Services. *Florida's Refugee Resettlement Program: 1989—The Year in Review*. Tallahassee, June 1990.

State of Iowa, Department of Human Services, Bureau of Refugee Services. *Bureau of Refugee Services' Resource Bibliography*. January 1993 ed. Des Moines, January 1993.

U.S. Committee for Refugees. *World Refugee Survey, 1994*. Washington, D.C.: American Council for Nationalities Service, 1994.

U.S. Conference of Mayors. *Immigrant Policy Issues for America's Cities: A 78-City Survey*. Washington, D.C.: U.S. Conference of Mayors, June 1994.

U.S. House of Representatives. Committee on the Judiciary. *Immigration and Nationality Act*. 102nd Cong., 2nd sess., 9th ed., April 1992.

U.S. Department of Health and Human Services, Office of Refugee Resettlement. *Directory: Films-Videotapes on Refugees*. Washington, D.C., 1991.

U.S. Department of Health and Human Services, Office of Refugee Resettlement. *Refugee Resettlement Program: Report to Congress. January 31, 1993*. Washington, D.C., 1993.

U.S. Department of Justice, Immigration and Naturalization Service. *Statistical Yearbook of the Immigration and Naturalization Service, 1992*. Washington, D.C.: GPO, 1993.

U.S. Department of Justice, Immigration and Naturalization Service. *Commissioner's Fact Book: Summary of Recent Immigration Data*, July 1991. Washington, D.C..

U.S. Department of Justice, Immigration and Naturalization Service. *Immigration Reform and Control Act: Report on the Legalized Alien Population*. Washington, D.C.,March, 1992.

U.S. Department of Justice, Immigration and Naturalization Service. *Naturalization Requirements and General Information*. Form N-17 (Rev. 08-23-88).

U.S. Department of Labor, Bureau of International Labor Affairs. *The Effects of Immigration on the U.S. Economy and Labor Market*. Immigration Policy and Research. Report no. 1, January 1989.

U.S. General Accounting Office. *The Changing Workforce: Demographic Issues Facing the Federal Government*. Washington, D.C., 1992.

U.S. General Accounting Office. *Illegal Aliens: Despite Data Limitations, Current Methods Provide Better Population Estimates*. GAO/PEMD-93-25. Washington, D.C., August 1993.

U.S. General Accounting Office. *Immigration Reform: Employer Sanctions and the Question of Discrimination*. GAO/GGD-90-62. Washington, D.C., March 1990.

U.S. General Accounting Office. *Refugee Resettlement: Federal Support to the States Has Declined*. GAO/HRD-91-51. Washington, D.C., December 1990.

Valdez, Burciaga R.; Julie DaVanzo; Georges Vernez; and Wade Mitchell. *Immigration: Getting the Facts*. Santa Monica: RAND, 1993.

Vernez, Georges. *Needed: A Federal Role in Helping Communities Cope with Immigration*. RP-177. Santa Monica: RAND, 1993.

Vernez, Georges and Kevin McCarthy. *Meeting the Economy's Labor Needs Through Immigration: Rationale and Challenges*. Santa Monica: RAND, 1990.

Vialet, Joyce C. "Refugee Admissions and Resettlement Policy." *CRS Issue Brief*. Washington, D.C.: Congressional Research Service, August 5, 1992.

Weissbrodt, David. *Immigration Law and Procedure*. 2nd ed. In a Nutshell Series. St. Paul, Minn.: West Publishing Co., 1989.

Zimmermann, Wendy, and Michael Fix. *Immigrant Policy in the States: A Wavering Welcome*. Washington, D.C.: The Urban Institute, July 1993.

A

Acculturation. *See* Assimilation
A Community Outreach Program (ACOP), 60-61
Administration on Children and Families (DHHS), JOBS and, 39
Admissions: *number of*, 68 (table); priorities for, 16; regulating, ix, 10
Adult Basic Education Act, 40
Adult Education Programs (Texas), 79
Advisory Committee on Refugee Affairs (St. Paul), 62
AFDC. *See* Aid to Families with Dependent Children
AFDC-UP. *See* Aid to Families with Dependent Children-Unemployed Parents
Aid to Families with Dependent Children (AFDC), xii, 12, 16, 17, 41, 44, 46, 69, 79, 85n7; cost-shifts for, 73; eligibility for, 76; expenditures for, 84; federal government and, 85n3; IRCA and, 38; JOBS and, 39; legal immigrants and, 15; regulations of, 48; reimbursement for, 67, 73
Aid to Families with Dependent Children-Unemployed Parents (AFDC-UP), 73, 85n5
Alabama, social service funds in, 80
Alaska Refugee Outreach, 42
Aliens, federal programs for, 7 (table)
Amerasian Initiative, 42
Amerasians, 19; benefits for, 16; mental health needs of, 28; resettlement of, 42; stress for, 27; views on, 51. *See also* Chinese; Vietnamese
American Public Welfare Association (APWA), 12; study by, xii, 66
Amnesty program, 8, 9, 17, 58
Anti-dumping laws, 80, 86n31
Anti-immigrant sentiment, 50, 58, 83
APWA. *See* American Public Welfare Association
Arizona, SLIAG and, 76
Arizona v. U.S. 85n7
Arlington County Bilingual Outreach, 58
Assembly Select Committee on Statewide Immigration Impact (California), 61
Assimilation, xi, 46, 49, 51-52; humanitarian immigrants and, 16; mental health and, 26-27; theories of, 50
Asylees, 8
Asylum, applications for, 15
Atlanta, immigrants in, 53
At-risk youth, training for, 35, 36
Avoiding Racial Conflict: A Guide for Municipalities (CRS), 57

B

Bach, Robert: on media, 62; on participation, 55; on segregation, 54
Benefits, reduction in, 68 (table)
Bernsen, Sam: on citizenship, 57
Bilingual/bicultural professionals, 25, 29, 30, 31, 32. *See also* Foreign-born professionals
Bilingual Education Act (1968), 59
Board of Immigration Appeals (BOIA), 10
Border Patrol, unauthorized immigration and, 18
Boston, community services in, 58
Boston City Hospital, health hotline at, 30
Bracero program, 50
Brown University, certification preparation at, 44
Bureau for Refugee Programs (Department of State), 10
Bureau of Industries and Immigration (New York), 53
Bureau of Refugee Programs (Department of State), 15

C

California: AFDC in, 73, 85n3; amnesty population in, 40; *benefit structures/payment levels of*, 74 (table); GA in, 76; health services in, 80; immigrant expenditures in, xii, 43, 73, 79, 84; immigrants in, 3, 55, 70; language services in, 40, 45, 77; reimbursement for, 69; SLIAG in, 40, 81; social services in, 79; welfare dependency in, 42
California Joint Committee on Refugee Resettlement, International Migration and Cooperative Development, 61-62
California Refugee Demonstration Project, 42
California v. U.S., 85n7
Cambodians, 49, 53; hiring, 60; mental health needs of, 28
Capital, access to, 61
Caribbean Research Center (City University of New York), 60
Carl Perkins Vocational and Applied Technology Education Act, 35, 43, 81
Cash and Medical Assistance (CMA), 16, 86n18
Catholic Conference demonstration project, 42
CBOs. *See* Community-based organizations
CDC. *See* Centers for Disease Control and Prevention
Center for Employment Training (CET), 37, 44, 45
Center for United States-Mexican Studies (University of California, San Diego), study by, 22
Centers for Disease Control and Prevention (CDC), 25
Central Brooklyn Federal Credit Union, loans from, 61
Central Brooklyn Partnership, 61
CET. *See* Center for Employment Training
Changing Relations: Newcomers and Established Residents in U.S. Communities (Bach), 55
Changing Relations Project, 52, 56; assimilation and, 52
CHCs. *See* Community health centers
Chicago: interethnic cooperation in, 57; literacy program in, 60
Chicago Travelers and Immigrants Aid, 29
Chiles v. U.S., 85n7
Chinese: exclusion of, 50; mental health needs of, 28
Chinese Exclusion Acts, 50
CHIRLA. *See* Coalition for Humane Immigrant Rights of Los Angeles
Choo, Marcia: on conflict resolution, 58
Citizenship, promoting, 55, 57-58, 62, 82
City on the Edge: The Transformation of Miami (Portes and Stepick), 52
Civic participation, 69, 81; promoting, 54, 55, 57, 58
Civil Rights Act (1964), language services and, 59
Clinica de Colores, 26
Clinton, Bill: welfare and, 46
Close Up Foundation, The, 58
CMA. *See* Cash and Medical Assistance
Coalition-building, 54, 55, 56
Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA), 61
Coining, 60
Colorado: SLIAG and, 76, 82; social service funds in, 80
Commission on Immigration Reform, 11; immigrant labor and, 51
Committee for Culturally and Linguistically Relevant Health Education, 30
Communications Consortium Media Center, 63
Community-based organizations (CBOs), 12, 39, 82
Community health centers (CHCs), funding for, 24
Community Innovations Project, 56

Community relations, 49, 55-57; ethnic diversity and, xi-xii; media and, 56; policymakers and, 54-55, 63; problems/solutions in, 50
Community Relations Service (CRS), 10-11, 57
Community Summit (Tacoma), 55
Congress, 10; funding from, 11
Connecticut, JOBS in, 39
Corporation for National and Community Service, 57
Cost-shifting, 69, 70, 74, 79, 80; direct, 67; significance of, 73; state-by-state, 85n13
Cross-cultural approaches, 28, 31
CRS. *See* Community Relations Service
Cuban entrants, 17, 19, 49, 52, 53; benefits for, 16
Cuban Exodus Relief Fund, 42
Cultural barriers, 27, 28-31, 54, 60

D

DED status. *See* Deferred enforced departure status
Deeming, 15, 86n34
Deferred enforced departure (DED) status, 19
Demonstration programs, 41-42
Department of Education, JTPA and, 37
Department of Employment (NYC), PHASE and, 44
Department of Health and Human Services (DHHS), xi, 11, 12, 74, 80; CHCs and, 24; cost calculation and, 75; health programs and, 25; interpretation services and, 29; JOBS and, 39; JTPA and, 37; migrant health centers and, 24; 100-hour rule and, 38; Refugee Resettlement Program and, 67; training/employment and, 39
Department of Housing and Urban Development, funding from, 61
Department of Income Maintenance (Connecticut), 39
Department of Justice (DOJ), 10; racial conflict and, 57
Department of Labor (DOL): agricultural workers and, 22; ESL and, 43; job displacement and, 39, 45; JTPA and, 35, 37; newcomers and, 2, 11, 34, 45
Department of Mental Retardation, 42
Department of State, 10, 12, 15
Deportation, 9, 50
DHHS. *See* Department of Health and Human Services
Dinkins, David, 52, 55
Disadvantaged Minority Health Act, 29
Discretionary projects, 41-42
Disproportionate share hospital (DSH) subsidy, 24
Diversity, ix, 9, 18; community relations and, xi-xii; coping with, 54-63; valuing, 51, 52
Diversity immigrants, 13-14
Division of State Legalization Assistance (DHHS), 11
DOJ. *See* Department of Justice
DOL. *See* Department of Labor
DSH subsidy. *See* Disproportionate share hospital subsidy

E

Economic opportunity, struggles over, 61
Economic Opportunity Act (1964), 36
Education, 67, 83; adult, 35, 45; bilingual, xi, 14, 46; health, 25; immigrants and, x, xi, 1, 3, 12, 14, 34, 51, 81, 84; SLIAG and, 40, 81, 82
Educational Opportunities Center, 37
Edward R. Roybal Comprehensive Health Center, 26
EIEA. *See* Emergency Immigrant Education Act
ELAs. *See* Eligible legalized aliens
El Centro de Latino, ESL by, 43
Eligibility, ix, 7 (table), 44-45, 63, 76, 83; determining, 10, 85n7
Eligible legalized aliens (ELAs), 71, 72, 74, 82; concentration of, 70; services for, 69, 76; survey on, 70
Emergency Immigrant Education Act (EIEA), 40, 87n36
Emergency services, 76; increased use of, 80, 83; newcomers and, xii, 3, 23, 31, 32
Employer sanctions, 17
Employment, x-xi, 34; barriers to, 44; demand for, 42-43; programs for, 35
Employment and Training Administration (Department of Labor), 11
Employment and Training (ET) Choices Program (Massachusetts), 39
Employment-based immigrants, 13; visas for, 14
Employment services, 41, 42, 76; expansion of, 80; reductions in, 79
English: proficiency in, 22, 53, 61, 79; training in, xii, 16, 39, 40, 41, 45, 56, 60, 69, 81; vocational, 41, 43, 80. *See also* Limited English proficiency
English as a second language (ESL), xi, 3, 31, 36, 39, 40, 45, 46, 76, availability of, 62, 79, 80, 81; demand for, 81, 86n27; funding for, 82; support for, 43. *See also* Language training
Entrepreneurship, barriers to, 61
EOIR. *See* Executive Office for Immigration Review
ESL. *See* English as second language
ET. *See* Employment and Training Choices Program
EVD status. *See* Extended voluntary departure status
Executive Office for Immigration Review (EOIR) (DOJ), 10
Extended voluntary departure (EVD) status, 19

F

Family-related immigrants, 13; visas for, 14
Family-sponsored immigrants, visas for, 14
Family Support Act (1988), JOBS and, 38
Family unity entrants, 19
Federal Bureau of Naturalization, citizenship classes by, 54
Federal policy, ix, 12-18; limits of, 66; states/localities and, 1
Federal programs, xi, 6, 8; eligibility for, ix, 7 (table), 10, 63
Florida: benefit structures/payment levels of, 73, 74 (table); ESL in, 81; health care in, 86n32; immigrant expenditures in, 73, 84; job training/placement in, 80; language services in, 77; Medicaid costs in, 23, 73; physician certification in, 44; reimbursement for, 69; SLIAG and, 76
Food stamps, 15, 17, 35, 85n7
Foreign-born population, 53, 66; *by state*, 78 (table)
Foreign-born professionals: hiring, 29; licensing, 31, 44

G

GA. *See* General Assistance
GAIN program (California), 38, 43
General Accounting Office (GAO): IRCA and, 18; on JTPA, 37; SLIAG study by, 74; on training programs, 42
General Assistance (GA), xii, 16, 83, 85n4; cost-shifting under, 73; expenditures for, 84; funding from, 76; medical benefits from, 24; reimbursement for, 67, 73
General Relief (GR): funding from, 76; medical benefits from, 24
Georgia: funding cuts in, 80; RMA in, 31
Georgia State University, ESL and, 43
GOIRA. *See* Governor's Office of Immigrant and Refugee Affairs
Governor's Immigration Coordinating Committee (Oregon), 62
Governor's Office of Immigrant and Refugee Affairs (GOIRA), 62
GR. *See* General Relief
Graham v. Richardson, 11
Green Card, 8
Guestworker programs, 50

H

Haitian entrants, 17, 19, 49, 52; benefits for, 16
Hawaii, refugee services in, 81
Head Start, 35
Health and Hospitals Corporation (NYC), PHASE and, 44
Health care: access to, 21, 22-24, 25, 80; barriers to, x-xi, 21, 25, 32; federal programs for, x, 25, 31; fragmentation of, x, 31; multilingual/multicultural, 25, 32; newcomers and, x, xii, 1, 3, 12, 21, 23, 31, 32, 46, 84; preventive, 21, 22, 80; primary, 22; reductions in, 79-80, 83; reform, x, 21, 32. *See also* Medical assistance; Mental health; Public health
Health, Education, and Welfare (HEW), 59
Health insurance, 21, 31
Health Resources and Services Administration (DHHS), health centers and, 24
Hepatitis B virus, 24, 25, 26
HEW. *See* Health, Education, and Welfare
Hispanic community, public health and, 26
Hmong, 26; barriers for, 62; hiring, 28; orientation for, 16
Holley v. Lavine, 38
House Appropriations Committee, funding from, 11
House Judiciary Committee, funding from, 11
Houston, media in, 63
Humanitarian immigrants, 6, 8, 12; assimilation and, 16; laws governing, 13; Refugee Act and, 15-17; TPS and, 13
Human Resource Investment Council (JTPA), 35, 44

I

IBM, ESL and, 43
Idaho: public assistance in, 76; SLIAG and, 82
Illegal aliens, 8; estimating, 18
Illegal immigration, 6, 8, 12, 18; IRCA and, 17; laws governing, 13
Illinois: *benefit structures/payment levels of*, 74 (table); cost-shifting in, 73; ESL in, 45, 81; funding cuts in, 80; job placement/training in, 79; language services in, 77; Medicaid costs in, 73; public health in, 26; reimbursement for, 69
Immigrant and Refugee Media Project, 63
Immigrant Education Act, 14
Immigrant Family Counseling Program, 82
Immigrant policy, 1, 10; for employment/job training, 39-42; immigration policy and, ix-x, 66; leadership on, 54
Immigrant Policy Project, ix, 12, 34, 54; goals of, vii; regional meetings of, 43
Immigrants. *See* Newcomers
Immigration: cities and, 53; costs and benefits of, 49, 82; *by decade*, 5 (figure); economic restructuring and, 49; federal jurisdiction over, xi, 10, 49, 50; immigrant policy and, ix-x, 66; impact of, 34, 62; increase in, ix, 18; legislation for, 89-90; restrictions on, 5, 6, 89; stress of, 26-27; types of, 6; waves of, 3, 5-6
Immigration Act (1965), 89
Immigration Act (1990) (P.L. 101-649), ix, 90; legal immigration and, 13-14
Immigration Amendments (1988) (P.L. 100-658), 90
Immigration and Nationality Act (1952) (P.L. 82-414), 13, 50, 89; Amendments (1965) to, 15
Immigration and Naturalization Service (INS), 6, 8, 10, 17, 62; citizenship and, 57; health insurance study by, 22; population survey by, 40
Immigration Reform and Control Act (IRCA) (1986) (P.L. 99-603), ix, xii, 1, 13, 55, 56, 89-90; AFDC and, 38; amnesty program in, 8, 9, 17, 58; DHHS and, 39; education costs and, 40; GAO and, 18; health care and, 23; illegal immigration and, 17, 18; JOBS and, 38; legalization and, 70; SLIAG and, 41, 69; state/local impact of, 17-18
Immunizations, cutting, 80
Impact aid funds, distributing, 83
Inclusive policies, developing, 54, 58-59
INS. *See* Immigration and Naturalization Service
Interpreters: hiring, 60; lack of, 29; training program for, 30
Iowa, VOLAGs in, 12
IRCA. *See* Immigration Reform and Control Act

J

Jeffco Employment and Training Services (Colorado), 41
Job Corps, xi, 36, 44, 46; multilingual curriculum for, 35, 37
Job Links, 40, 42, 80, 86n32
Job Opportunities and Basic Skills Training Program (JOBS), xi, 34, 35, 42, 43, 46; AFDC and, 39; evaluation of, 38-39, 45; funding for, 39; IRCA and, 38
Job Training Partnership Act (1982) (JTPA), 34, 35, 42, 46; evaluation of, 37, 45; language proficiency and, 39; newcomers and, xi, 43-44; performance standards of, 37-38; purpose of, 36; women/minorities and, 37
Joint Subcommittee Studying the Needs of Foreign-Born Individuals in the Commonwealth (Virginia), 61
JTPA. *See* Job Training Partnership Act
Judicial mandates, 11

K

Kellogg Foundation, grant from, 30
Kentucky, social service funds in, 80
Key States/Counties Initiative, 40, 42
Know-Nothings, 50

L

Labor, 2, 51; clashes over, 61; multilingual/multiethnic, 34
La Cooperativa (Sacramento), workforce development by, 44
Language barriers, 34, 45, 60; problems with, 27, 28-31, 52-54. *See also* Limited English proficiency; Literacy
Language training, 54, 57, 59-60; demand for, 81, 82; investment in, 83; reductions in, 76-77, 79, 80, 84. *See also* English as second language
Latino Employees Association, 59
Latinos: asylum for, 15; job placement for, 39; views on, 51
Law enforcement, 3; outreach by, 60-61
Lawful permanent residents (LPR), 6, 14, 15; federal assistance for, 8
Law v. Nichols, 59
Legal immigrants, 6, 8, 12; laws governing, 13-14; medical care for, 24; services for, 15, 22; *by state* , 9 (figure); state/local impact of, 14-15
Legalization, 69; *applying for*, 13, 17, 70, 72 (table)
Legalized aliens, 8; citizenship and, 58
Legalized Population Survey (INS), 40
LEP. *See* Limited English proficiency
Lewis v. Grinker, 11
Limited English proficiency (LEP), 9, 23, 34, 37, 58, 59, 76, 77; *by state*, 78 (table). *See also* Language barriers
Linkages, establishing, 35
Literacy: barriers to, 34; promoting, 60. *See also* Language barriers
Los Angeles: community building in, 56; ESL in, 79; immigrants in, 55-56; interethnic cooperation in, 57; LEP in, 60; media in, 63; welfare dependency in, 42
Louisiana, cost rejections for, 75
Lowell: immigrants in, 53; minority officers in, 60
LPR. *See* Lawful permanent residents

BEST COPY AVAILABLE

M

McCarran-Walter Act. *See* Immigration and Nationality Act
MAAs. *See* Mutual assistance associations
Maine: education in, 80-81; social services in, 79
Mainstreaming, targeted programs vs., 43-44
Manpower Demonstration Research Corporation (MDRC), report by, 38
Maryland: Refugee Program in, 80; SLIAG and, 82
Massachusetts: cost rejections for, 75; ESL in, 79; SLIAG and, 76, 82; social services in, 79; welfare dependency in, 42
Massachusetts Department of Public Health (MDPH), 30
MDPH. *See* Massachusetts Department of Public Health
MDRC. *See* Manpower Demonstration Research Corporation
Media: attention from, 49; community relations and, 56; newcomers and, 62-63
Medicaid, 12, 16, 17, 39, 69, 80; cost and benefits of, 22, 73, 84; cost-shifts for, 73; eligibility for, 76; federal government and, 67, 85n3; interpretation services and, 29; mental health and, 27, 28; newcomers and, xii, 11, 23, 31, 41; reimbursement for, 23, 67, 73; undocumented immigrants and, 23
Medical assistance, 8, 24, 83; limits on, 79-80; *reduction in*, 68 (table), 76; rejecting, 86n18. *See also* Health care
Medi-Cal program, costs for, 22-23
Medicare, 12; mental health and, 27, 28
Melting pot metaphor, 50, 51-52
Mental health, x, 26-28; access to, 21; funding for, 27; problems in, 27, 80; state/local programs in, 28
Mental Health Block Grant, 27, 28
Mental Retardation and Substance Abuse Services (VDMH), 30
Miami: bicultural living in, 52; community liaison program in, 58; immigrants in, 53
Michigan, welfare dependency in, 42
Microenterprise Development Initiative, 42
Microsoft, ESL and, 43
Migrant health centers, funding for, 24
Migrant Health Program, 25
Migrant workers, 35; JTPA and, 36
Minnesota: refugee programs in, 43; SLIAG funds for, 74; welfare dependency in, 42
Minnesota Interagency Adult Learning Council, 43
Montana, health services in, 80
Monterey Park, Asians in, 53, 54
Multicultural, Multilingual Task Force, 59
Multilingual/multicultural resources, using, 32, 58
Mutual assistance associations (MAAs), 12, 82

N

National Association of Counties, 41, 58
National Center for Research in Vocational Education, 45
National Commission for Employment Policy, 35, 36; on training programs, 42
National Immigration Forum, 63; community relations and, 56
National Institute of Mental Health, 27
National Literacy Act, 35
Naturalization, 19; applicants for, 57; outreach for, 82
Neighborhood Services Liaison, 58
Neighborhood Watch program, 55
Nevada: Refugee Program and, 81; SLIAG and, 82
Newcomers, 6, 8-12; ambivalence toward, xi, 1-2, 49, 50, 51, 54-55, 62-63; *assistance for*, 4 (figure); barriers for, 9; *benefits for*, 22, 68 (table); concentration of, 70; conflict among, 57; contributions by, 2, 3, 21, 62-63, 66; cooperation among, 54-55; *cumulative arrivals of (by state)*, 10 (figure); diversity of, ix, 9, 18; federal funding for, xii, 1; media and, 49; number of, 18, 21; origins of, 6; state-level offices for, xii; state/local impact of, 14-15; state/local spending on, xii-xiii, 1, 3, 73-76; survey on, 70
New Horizon Community Mental Health Clinic (Miami), 28
New Jersey: cost rejections for, 75; employment/training in, 43; Refugee Program and, 81; SLIAG and, 82
New Mexico, refugee services in, 81
New York: immigrant services in, 12; LEP in, 60; reimbursement for, 69; SLIAG funds for, 74; welfare dependency in, 42
New York Association of New Americans (NYANA), 44, 45
New York City: ESL in, 79; health careers in, 31; immigrant services in, 12; immigrants in, 3, 53, 55; interethnic cooperation in, 57; translation services in, 60
New York Coalition on Immigration, 55
New York Legislative Commission on Skills Development and Vocational Education, 44
New York State Health Transition Initiative, 44
New York State Refugee and Immigrant Health Professional Transition Initiative, 31
Nintendo, ESL and, 43
Nongovernmental organizations, 83; citizenship and, 58; resettlement and, 12
Nonimmigrants, 12-13, 19
North Carolina, SLIAG and, 82
Nurses Tutoring Project (Chicago), 31
NYANA. *See* New York Association of New Americans

O

ODP. *See* Orderly Departure Program
Office for Minority Health (OMH) (DHHS), 29
Office for New Americans (Maryland), survey by, 85n2
Office for Refugee and Immigrant Health (Massachusetts), 30
Office of Deputy Assistant Secretary for Minority Health (DHHS), 29
Office of Immigrant Affairs (NYC), 12
Office of Mental Health (NYC), PHASE and, 44
Office of Refugee Resettlement (ORR) (DHHS), 11, 16, 27; health programs and, 25; Job Links and, 86n32; national discretionary projects and, 42; public health and, 26; Refugee Resettlement Program and, 67; survey by, 70, 79; Targeted Assistance and, 40, 41
Oklahoma, health services in, 80
OMH. *See* Office for Minority Health
Omnibus Budget Reconciliation Act (1986), reimbursement and, 23
100-hour rule, waiving, 38
Operation Wetback, 50
Orderly Departure Program (ODP), 26
Oregon: cost-shifts in, 74; health care access in, 25; IRCA in, 62; public health in, 26; REEP in, 41-42
ORR. *See* Office of Refugee Resettlement

P

Pacific Medical Center (Seattle), interpreter forum at, 30
Parasitic infections, 24-25
Parolees, 8
Pennsylvania: cost rejections for, 75; SLIAG and, 76
Permanently residing under color of law (PRUCOL) status, 19, 38
Permanent resident aliens, 6
PHASE, establishment of, 44
PICs. *See* Private Industry Councils
Placement services. *See* Employment services
Planned Secondary Resettlement, 42
Plyler v. Doe, 1, 11, 59
Police, 3; outreach by, 60-61

Policymakers, community relations and, xi, 54-55, 63
Post-traumatic stress syndrome, 27
Preference system, 13, 14, 50
Preventive health care, 21, 22; funding cuts for, 80
Preventive Health Services, 16
Private Industry Councils (PICs), 36; ESL and, 43
Professionals. *See* Binlingual/bicultural professionals; Foreign-born professionals
Program for New Americans, 58
Program funding, by service type, 77 (table)
Program planning, 18, 42-43
PRUCOL status. *See* Permanently residing under color of law status
Public assistance programs, refugee participation in, 76
Public charge, 15, 86n34
Public health, x, 21, 24-26; federal funds for, 26; state/local programs for, 26. *See also* Health care
Public Health Service: health programs and, 25
Public hospitals, 23-24

Q

Quotas, national origin, 50, 89

R

Race relations, 57; media and, 49
RCA. *See* Refugee Cash Assistance
REEP. *See* Refugee Early Employment Project
Refugee Act (1980) (P.L. 96-212), ix, 1, 13, 67, 89; humanitarian immigration and, 15-17; priorities in, 16; resettlement program by, 39; social services and, 40-41
Refugee arrivals: resettlement funds vs., 4 (figure); *by state*, 71 (table)
Refugee assistance, reimbursement for, 4 (figure)
Refugee Assistance Act (1980), Title V of, 19
Refugee Assistance Amendments (1982) (P.L. 97-363), 89
Refugee Assistance Extension Act (1986) (P.L. 99-605), 89
Refugee Cash Assistance (RCA), 16, 67, 85n4
Refugee Early Employment Project (REEP) (Oregon), 41-42
Refugee Education Assistance, 15
Refugee Medical Assistance (RMA), 16, 22, 23, 31, 67, 80, 85n4
Refugee Policy Group, REEP and, 42
Refugee Program, 67, 80, 85n8, 86n21; cutbacks in, 69, 71, 73, 83-84; employment and, 79; legacy of, 81-82, 84; spending for, 84; state costs for, 66; survey on, 70, 73
Refugees. *See* Newcomers
Refugee Targeted Assistance, mental health and, 27
Reimbursement, 4 (figure), 18, 23, 25, 67, 73, 82; rejecting, 70, 75; seeking, 69, 83; shortening period for, 74. *See also* Uncompensated costs
"Report on Southeast Asian Family and Youth Issues," 62
Resettlement, 18, 39; assistance for, ix, 3, 10, 11-12; difficulties with, 66, 70; health care and, x, 22; pattern of, 70; *paying for*, 11, *68* (table); state/local governments and, 16-17
Resettlement funds, refugee arrivals vs., 4 (figure)
Rhode Island: public health and, 26; SLIAG funds for, 74
RMA. *See* Refugee Medical Assistance
Roanoke City Health District Refugee Clinic, interpreter services at, 30

S

Safe Street program, 55
St. Paul: outreach in, 60-61; Southeast Asians in, 62
St. Paul International Clinic, cross-cultural approach at, 28
Salad bowl metaphor, 50, 51-52
San Diego, diversity training in, 59
San Francisco, Job Corps in, 35, 37
San Jose, CET in, 37
Santa Clara County Mental Health Bureau: ethnic composition of, 30; Southeast Asians and, 28
SAVE. *See* Systematic Alien Verification for Eligibility system
SAVE. *See* Systematic Alien Verification for Entitlements system
SAWs. *See* Special agricultural workers
SDAs. *See* Service Delivery Areas
Segregation, institutional/residential, 54
Self-sufficiency, xi, 3, 9, 15, 42, 46, 60; health care and, 22, 32; promoting, 62, 63, 67
Senate Appropriations Committee, funding from, 11
Senate Judiciary Committee, funding from, 11
Service Delivery Areas (SDAs), 36, 37-38, 43, 44
Services: availability of, 45; costs of, 66-67, 71, 74; eligibility for, 44-45; reduction in, 76. *See also* Various services by type
Simpson-Rodino Act. *See* Immigration Reform and Control Act
SLIAG. *See* State Legalization Impact Assistance Grant
Social Security Act, Title XX of, 40, 41
Social services, 3, 16, 23, 40-41; cutbacks in, 76, 80; federal funds for, xii; maintaining/expanding, 80-81; reduced federal support for, 79
Social Services program, ORR and, 40
South Carolina, SLIAG and, 82
Special agricultural workers (SAWs), 8, 17, 85n8
Sponsors, 15
SSI. *See* Supplemental Security Income
State and Local Coalition on Immigration, vii, ix, 66
State Employment and Training Commission, 43
State Job Training Coordinating Council (JTPA), 36, 43, 44
State Legalization Impact Assistance Grant (SLIAG), xi, xiii, 11, 23, 45, 46, 71, 75, 76, 85n8, 90; certification and, 44; changes for, 66; cost-shifting under, 74; *costs of*, 66, 81 (table); creation of, 17; cutting, 84; DHHS and, 39, 40; education and, 40, 81, 82; funds for, 69, 74; GAO study on, 74; IRCA and, 41; legacy of, 67, 81-82, 83, 84; managing, 62; survey on, xii, 70
State Refugee Office (Oregon), survey by, 85n2
Sudomir v. McMahon, 38
Supplemental Security Income (SSI), xii, 12, 16, 17, 41; cost-shifts for, 73; eligibility for, 85n7; legal immigrants and, 15; reimbursement for, 67, 73
Systematic Alien Verification for Eligibility (SAVE) system, 22
Systematic Alien Verification for Entitlements (SAVE) system, 17

T

Tacoma, immigrants in, 55
Target Assistance, 16, 27, 42, 80; ORR and, 40, 41
Targeted programs, mainstreaming vs., 43-44
Task Force on New Americans (New York), 62
Taxes, newcomers and, 2, 11, 14, 18
Temporary protected status (TPS), 13, 19, 50
Texas: AFDC costs in, 85n3; *benefit structures/payment levels of*, 73, 74 (table); county assistance programs in, 76; ESL in, 79, 81; funding cuts in, 80; health services in, 80; immigrant services in, 12; job training/placement in, 79, 80; language services in, 77; Medicaid costs in, 23; reimbursement for, 69; SLIAG and, 76, 82
TPS. *See* Temporary protected status
Traditional healing practices, 60
Training, x-xi, 3; demand for, 42-43, 82; direct, 35; expansion of, 80, 83; federal, 34, 35; on-the-job, 35, 36, 37, 39, 41, 44; reduction of, 67, 76-77, 79; self-sufficiency, xi; vocational, 41
Translators: hiring, 60; lack of, 29; state/local programs for, 30
Transnational Institute for New American Students, 60

Tuberculosis: incidence of, 24, 26; treatment of, 25
20-hour rule, 38

U

Unauthorized immigrants, 6, 8, 12, 18; IRCA and, 17; laws governing, 13; number of, 17
Uncompensated costs, 18, 23; *by state/by program*, 75 (table). *See also* Reimbursement
Underground health systems, 23
Undocumented immigrants, 8; costs for, 85n7; education benefits for, 1; health care and, 22, 23; Medicaid and, 23; reimbursement for, 69; SLIAG and, 41
Unemployment Insurance Board, 44
University of Illinois, Chicago: survey by, 29
Urban Institute, xi, 12, 66; on immigrant welfare use, 51; on unauthorized migrants, 18
"Using Health Care Services" (videotape), 26
Utah: ESL in, 79; health services in, 80

V

VDMH. *See* Virginia Department of Mental Health
Vending, clashes over, 61
Vermont, VOLAGs in, 12
Videotapes, multilingual, 26
Vietnamese: asylum for, 15; hepatitis B virus and, 24; special needs of, 28, 42
Virginia: ESL in, 79; immigrant services in, 12; licensing reciprocity in, 44; SLIAG and, 82
Virginia Department of Mental Health (VDMH), 30
Visas: diversity, 34; extraordinary ability, 34; family, 34, 50; immigrant, 8; nonmigrant, 8, 10; permanent residence, 8; preference system for, 13, 14, 50; worker, 34
Vocational Education Board, 44
Vocational English as a Second Language program (Georgia), 43
Vocational Rehabilitation of Massachusetts, 42
Voluntary agencies (VOLAGs), 12
Voluntary Agency Matching Grant, 16; mental health and, 27
Voluntary departure status, 19

W

Wagner-Peyser employment service, 35, 43
Washington, D.C.: interethnic cooperation in, 57; SLIAG funds for, 74
Washington state: *benefit structures/payment levels of*, 74 (table); cost-shifting in, 73; health services in, 80; immigrant expenditures in, 73-74, 84; job training/placement in, 80; language services in, 80; Medicaid costs in, 73; SLIAG funds for, 74; welfare dependency in, 42
Welfare, 24; eligibility for, 83; legal immigrants and, 15; newcomers and, xii, 2, 51, 69, 73, 83, 85n12, 86n34; self-sufficiency and, xi
Welfare reform, xi; Clinton and, 85n7, 86-87n35; Republicans and, 85n7
Welfare-to-work transition, xi, 38, 46
WIC. *See* Women, Infant, and Child program
Wilson/Fish Demonstration projects, 40, 41, 42
Wisconsin, welfare dependency in, 42
Women, Infant, and Child (WIC) program, 24
Women and Infants Hospital (Rhode Island), public health and, 26
Work and Responsibility Act (1994), 87n35
Workforce. *See* Labor

America's Newcomers

An Immigrant Policy Handbook

More immigrants and refugees are coming to the United States today than at any time since the turn of the century, and the large number and great diversity of newcomers are dramatically affecting states and localities. Although the federal government sets *immigration* policy (the terms for entry into the country), states and localities have become responsible for *immigrant* policy, that is, the policies that help newcomers assimilate into the country's economic, social, and civic life. This book is a reference on immigrant policies for state and local policymakers.

Produced by the Immigrant Policy Project of the State and Local Coalition on Immigration, this comprehensive handbook

- presents an overview of U.S. immigration, federal governance, and the effect of immigration on states and localities;
- offers discussion of health care issues, employment and training programs, and community relations and ethnic diversity; and
- summarizes the results of a survey on the fiscal, programmatic, and institutional effects on states of reduced targeted federal assistance for immigrants and refugees.

It also includes a chronology of U.S. immigration legislation, a list of contacts on immigration and immigrant policy, and a bibliography of recent publications on these topics.

The Immigrant Policy Project

The Immigrant Policy Project of the State and Local Coalition on Immigration is a collaboration of five national organizations representing state and local government:

American Public Welfare Association
National Association of Counties
National Conference of State Legislatures
National Governors' Association
United States Conference of Mayors

The project is funded by the Andrew W. Mellon Foundation to address the role of state and local governments in the resettlement of refugees and immigrants. Other issue papers of the project examine immigration trends and their effect on state and local government; health care issues; and community relations.

State and Local Coalition on Immigration
Immigrant Policy Project

Item # 9366
Price: $35.00

ISBN 1-55516-996-1